Registered at the G.P.O., Sydney, for Transmission by Post as a Newspaper. Published Weekly.

# THE MEDICAL JOURNAL OF AUSTRALIA

(With which "The Australasian Medical Gazette," and "The Australian Medical Journal" are incorporated.)

The Journal of the Australian Branches of the British Medical Association.

VOL. II.—5TH YEAR—No. 21. SYDNEY: SATURDAY, NOVEMBER 23, 1918. PRICE 6D.

# THE MEDICAL JOURNAL OF AUSTRALIA.

VOL. II.—5TH YEAR. SYDNEY: SATURDAY, NOVEMBER 23, 1918. No. 21.

## EMERGENCY SURGERY.

### Notes on 166 Consecutive "Immediate" Operations Performed at the Melbourne Hospital.

By **Athol S. M. Tymms, M.D., M.S. (Melb.),**
*Acting Surgeon to Out-Patients, Melbourne Hospital; Examiner and Demonstrator in Anatomy, Melbourne University.*

*(Continued from page 409.)*

*(ii.) Intestines.*

*Acute Intestinal Obstruction.*—Of all intestinal cases met with in this series of immediate operations, those of acute obstruction were the most disheartening and difficult to deal with. This was mainly because one was unfortunate enough to meet with cases in patients of advanced years. But it must be remembered that these patients had frequently delayed until obstruction was well advanced before seeking advice, or the underlying cause was such as to hold out but little hope of permanent relief; whilst the difficulties at operation were great from the amount of bowel distension encountered.

The obstruction here referred to is the primary mechanical variety, not the dynamic, due to peritonitis, though, in the advanced stages, both varieties are in evidence. That the latter may be mistaken for the former may be seen in cases mentioned under appendicitis.

The obstruction was due to three main causes: incarceration of bowel loops within orifices of hernial sacs; strangulation of coils by old peritonitic adhesive bands; and obstruction by malignant growths within the bowel itself.

An examination of the hernial orifices and of the rectum is essential in every case presenting symptoms of obstruction, and is too often neglected in the early stages.

*Obstruction Due to Herniæ.*—These comprised inguinal, femoral and umbilical cases. There were eight inguinal herniæ giving rise to obstruction, and of these seven were in males, four being right sided. The average age of the patients was 50 years, and the herniæ were mostly of long standing.

In two cases the sac contained large bowel, whilst three contained omentum in addition to small bowel. Two were merely obstructed, whilst the remainder were strangulated to varying degrees.

The obstruction occurred at the abdominal inguinal ring, except in one case, which was a direct hernia immediately lateral to the *falx inguinalis* (conjoined tendon). Two patients had their hernia reduced by a doctor, but symptoms of obstruction, though not severe, continued, and they were admitted to hospital.

In one a small knuckle of bowel was caught just within the ring, but the other was a very instructive case, wherein the sac containing the loop of small bowel, strangulated at the abdominal inguinal ring, had been reduced within the abdominal cavity *en bloc* by invaginating the peritoneum around the ring, so that within the abdomen was the sac containing, within it, the tightly strangulated loop of bowel. From outward appearances, there was no evidence of hernia.

In no case was resection of bowel necessary, though several were doubtful cases to leave. In one case Halstead's, and in the remainder Bassini's, operation was used.

One patient only died, and this unexpectedly on the second day. An autopsy disclosed a condition of tuberculous mediastino-pericarditis complicating phthisis. The obstruction had been slight, and prior to operation there was a doubt as to whether the case was not uræmia.

The female patient, aged 32, presented an interesting case. She was sent in with a diagnosis of "strangulated right inguinal hernia, ? ovary in sac." At the operation a mass resembling a congested, enlarged ovary was found in the canal, but was rather extra-peritoneal than intra-peritoneal in relation to the sac, which was of small size and contained no bowel. The mass was removed. On exploring through the opened sac to ascertain if the ovary were present within the abdomen, a large myomatous uterus was felt. Operation was performed for this condition a few days later, but the patient died. There was found no apparent cause for this termination, beyond shock of the two operations and lowered resistance. The ovaries were normally placed and healthy, and the uterus did not appear malignant.

Of the femoral herniæ there were three cases, one in a male and two in females. Their ages were respectively 62, 65 and 80 years, and the condition was right-sided in all.

The case in the male was a Richter hernia. As it was not possible to draw down a small, quite grey knuckle through the femoral ring, the abdomen was opened and the hernia dislodged and found to be a portion of the convex surface of a coil of small bowel which was incarcerated. From its appearance it resembled a Meckel's diverticulum. Ten centimetres of ileum were resected. The patient died on the second day.

In the case of the female of 80 years of age, the abdomen was explored for malignant disease, as it was thought probable that the hernia was not the chief cause of obstruction, but the bowel could not be reduced from the ring within the abdomen, because of the amount of omentum surrounding the knuckle of bowel within the sac. Femoral incision was therefore required. Radical operation was not performed. The patient did excellently as regards the operation, but died of debility after ten days.

The third patient was extremely ill. On exploration from the abdomen, a loop of small bowel was found to have reduced itself from the femoral ring, and an enterostomy was performed for relief of the distension. The patient, however, collapsed during the operation.

*Umbilical Hernia.*—Of these there were three cases in females, aged respectively 55, 64 and 75 years. In all the herniæ were of very long standing and the pa-

tients very obese. In two a vertical elliptical incision was used. The sac contained the transverse colon and omentum in both, and there were the usual loculi within the sac.

The youngest patient presented signs of heart failure, and died the following day, the post-mortem examination showing fatty degeneration of heart, with hypostatic pneumonia and heart failure.

In the second case there was merely obstruction without strangulation, but the hernia was of very long standing. When the neck of the sac was opened, dirty, fœtid fluid was noticed in the abdomen. On investigation, several stercoral ulcers of the right colon were found, two of which had perforated, causing a localized abscess, which later had spread to a generalized peritonitis.

The third case was that of a woman of 75 years of age with a fibrillating heart, who took the anæsthetic rather better than was expected. A transverse elliptical incision was used, and here it was found that omentum covered a coil of small bowel which was completely gangrenous. This was resected and an end-to-end anastomosis performed. On the second day there was a good deal of pain and very marked and prominent distension of the abdomen (small bowel obstruction), but no vomiting. Recognizing that further operation would be disastrous in such an elderly patient, one had recourse to frequent enemata without success, but with the exhibition of large doses of purgatives (calomel, *pulv. jalap. co.* and castor oil) one risked the tearing of the sutures, and was rewarded with success.

As instancing how disheartening such cases are, this patient had a heart attack on the seventh day and died suddenly, just when one's efforts appeared to be successful.

*Adhesions.*—The commonest cause of obstruction from adhesions is an abdominal operation performed previously for infective conditions, the chief of which are appendicitis and salpingitis.

That a long time should have elapsed since the primary operation is not necessary for a diagnosis of obstruction by bands.

An important aid in diagnosis of obstruction is the detection of peristaltic waves, and these should be looked for with care, particularly those of the small bowel. The fact that the bowels have acted, even several times, does not dispose of a diagnosis of obstruction. The cases in this series were in three young females. One had been operated on five weeks previously for appendicitis without drainage. Her symptoms were epigastric pain, with retching, lasting several days almost continuously; she was admitted as a case of leaking ulcer of the stomach. This symptom of continuous vomiting was against perforation of an ulcer, and it was only the presence of slight, but definite peristalsis and commencing distension that suggested obstruction. The raw edge of the divided mesentery in the appendicectomy operation previously had adhered to a loop of small bowel obstructing beneath it a second loop.

A second case also followed appendicectomy; in this case the operation had been performed for an appendical abscess six months previously. Here again the same signs of peristalsis and slight distension led to operation.

An adhesion between the appendical stump and the right tube was the cause, though other loops of bowel were adherent from old peritonitis. Five weeks later this patient returned with similar obstruction, and an omental graft was used to cover the raw area where the adhesions were freed, but three weeks later the same symptoms of obstruction were still present. At this third operation for obstruction about 60 cm. of knotted bowel were resected. Though pregnant, the patient went through these operations without mishap.

The third patient had had an abdominal-wall abscess drained, and before this healed, was operated upon for obstruction. It was found that the great omentum was adherent to a hard, cheesy mass on the ventral wall of the bladder, and in this position crossed the root of the mesentery so tightly that it obstructed quite a number of coils of small bowel. After the relief of this obstructing band the patient got well.

*Malignant Tumours of the Bowel.*—Of the four cases with acute obstruction three were in males, whilst the average age was over 60 years. All were extremely ill, with marked distension, and, with one exception, had been ill for some weeks previously. All were cases of carcinoma of large intestine. The great distension of the large bowel was a bar to localization of the obstructing growth, nor was this usually necessary. In one case in which the caecum was distended and the sigmoid and rectum clear, the presence of the hand within the abdomen caused the distended transverse colon to rupture above the obstructed mass. Autopsy disclosed a large foul, ulcerating carcinoma at the splenic flexure.

In the case of a female with a scirrhus of the rectum, the distension of the caecum and of the sigmoid was enormous, so that left inguinal colostomy was difficult to perform. This patient was operated upon unsuccessfully some eight weeks later by the combined abdomino-perineal method. Naturally the only thing that should be done in these urgent cases is to drain the bowel by an opening above the obstruction. Usually an inguinal colostomy is indicated, but where an ileostomy is required, the laparotomy incision suffices.

In performing ileostomy, an opening high in the small bowel should be guarded against, but where the distension of the gut is great this is often somewhat difficult to avoid.

It should be remembered that in left inguinal colostomy for obstruction in the rectum or sigmoid it is necessary to leave as much bowel as possible between it and the growth, as this may be essential in the performance of a subsequent radical operation.

*Rupture of Intestines.*—That rupture of intestines may not necessarily occur at or near the junction of a fixed and movable part of the bowel was demonstrated in two cases, and, further, the nature of the trauma in these two cases was rather unusual.

A Chinaman was admitted with a rigid abdomen and a history that, whilst wrestling 26 hours previously, he felt pain in the abdomen. He did not think that he had been struck, and there was no abdominal wall injury. The bowel was not distended, and there was no gas or free fluid. A loop of bowel presented,

showing a tear with extruded mucous membrane 1.25 cm. in diameter, situated about one metre from the caecal extremity. It was closed by a purse-string suture and the abdomen drained for safety. There was no other lesion, and he did excellently.

A second patient, a man, aged 66, gave a history that, whilst lifting a heavy box on to a table, he felt something "give" within the abdomen. There was no injury to the abdominal wall.

The abdomen was generally rigid, and there were signs of peritonitis on opening. In about the middle of the small bowel a loop was found with lymph covering a tear 6 cm. in diameter, and with extruded mucous membrane. The abdomen was carefully explored for malignant disease, ulceration of the bowel, etc., but with negative result. He lived for twelve days, when his wounds were quite healed. He died from debility. A post-mortem examination did not disclose any further lesion.

The third case was of the usual type. Thirty-six hours previously the patient was knocked down amongst some timber. He did not notice any injury to the abdomen, but had vomited blood. The condition was diagnosed as ruptured stomach. There was merely bruising of the greater curvature of the stomach, but the jejunum was found almost completely torn across about 5 cm. from its junction with the duodenum. General peritonitis, with distension, was well advanced, and he died the day folowing.

In all these cases the abdominal rigidity was centrally placed.

*Appendicitis and Typhlitis.*—It will be seen that appendicitis constitutes nearly half the total number of cases included in the series. In every case this was the primary cause of the illness.

Appendicectomy performed for other acute conditions is not included.

There were 52 males and 23 females, with an average age respectively of 30 and 26 years. The youngest male case operated on was 11 years old, whilst the oldest was 87 years of age.

Both had generalized peritonitis from a perforated appendicitis. The youngest female was 12 and the oldest 50 years of age.

In the majority of the cases the duration of the illness was under one week, usually one to three days. The four cases where the illness was longer than seven days included the three deaths in the series.

Abdominal pain and tenderness were chiefly in three regions: epigastric, umbilical and right iliac fossa, and the typical spread of these from the umbilicus and the epigastrium to the iliac fossa were often noted. Three cases where the pain was epigastric, were particularly interesting.

Intense pain was felt in the costal angle, from 8 to 56 hours, and never moved from this position. The temperature and pulse in two or three were normal under observation, whilst tenderness in the right iliac fossa could only be elicited by very firm and deep pressure. These three cases each contained the appendix tucked within the ileo-caecal fold and in contact with the root of the mesentery, two being swollen and full of pus (pus-appendix), whilst the third was a very long, inflamed appendix, containing three concretions.

Again, it was noted in several cases that pressure over the appendix did not elicit local tenderness, but rather acute pain in the epigastrium. This same epigastric pain was the chief symptom in two cases of acute obstruction in which the root of the mesentery was involved by adhesive bands. The explanation of this would appear to be the fact that where there is any interference with dorsally fixed peritoneal folds, there is produced vagus irritation referred to the solar plexus. The point is significant, as an appreciation of the causation of this epigastric pain may be of value in the differential diagnosis of abdominal lesions.

R. J. A. Berry, in his "Pathology of the Vermiform Appendix," laid stress upon the lodgement of the appendix in the caecal fossæ, as predisposing to appendicitis.

Although these three cases were situated in the ilio-caecal fossa, Berry was able to mention only one author who had met with the appendix in this position.

Common errors in diagnosis include salpingitis, duodenal ulcer, cholecystitis and even early intestinal obstruction. Again, renal and gall-bladder conditions may be mistaken for appendicitis. Thus, in a boy who had had an appendicectomy performed five weeks previously, a stone was removed from the renal pelvis because of persistence of the pain in the right side.

In one case the pain was left-sided, suggesting left-sided appendix, whilst several others were hypogastric in position. In these cases the appendix was situated in the pelvis, just caudal to the bifurcation of the aorta. In a few male patients urinary symptoms were present. Usually the appendix condition involved the ureter, but it is wise always to ensure that a Neisserian infection is not present as well, and one should be careful to eliminate this infection with epididymitis, or hernia, where the abdominal tenderness is over the inguinal canal.

In females differentiation must be made from tubal conditions. It was safe to regard the condition as purely appendical if the patient were under 18 years and single.

The investigation of the discharge, the examination of the urine, and particularly the pelvic examination, should always be carried out. But, despite these, and where the latter could not be determined, an accurate diagnosis was not always possible.

A mid-line incision should then be used. It may be difficult to distinguish whether the appendix or the tube is the primary condition where both are involved, as so frequently occurs. In one case it was necessary to demonstrate that either a gangrenous condition or perforation was the primary condition, and not salpingitis.

One woman confined twelve days previously had a large subinvoluted uterus, with infected tubes and mild peritonitis, but a markedly gangrenous appendix.

In eleven cases a mass could be felt in the abdomen, usually in the right iliac fossa, but at times in the middle line. Seven were described as having an abscess, in twenty-eight the mass was gangrenous, whilst in seven it was particularly noted that perforation had taken place. Five had generalized peritonitis, four were pus-appendices, one a mucous cyst of the appendix, whilst the remainder showed the varying

grades of acute inflammation, mostly of the nature of a chronic inflammatory thickening.

One man, who had a general peritonitis of seven days' standing, with subnormal temperature throughout his stay in hospital, unexpectedly did well and was discharged in four weeks. He returned five weeks later with a huge subphrenic abscess, which extended to the loin. A large pleural effusion followed without becoming an empyema, and in the midst of this his bowel became strangulated in abdominal adhesions. From all these he made a very good recovery.

In another case with a subhepatic collection of pus at the time of the operation the signs of empyema developed, as expected, but one aspiration relieved this without rib resection becoming necessary.

The position of the appendix was noted in thirty-four cases to be in the right iliac fossa, either enclosed in the omentum, adherent to the caecum, lying against the mesentery, or free; whilst in fourteen cases it was lying over the brim of the pelvis, free in the pelvis, or adherent to the ovary, tube or bladder. In eight cases it was found retro-caecal, whilst in one of these it was altogether retro-peritoneal as well. In a few it was well over in the mid-line of the abdomen, whilst in the remainder no note was made of its position.

The appendix was approached through the muscle-splitting incision (McBurney) in forty-nine cases, mid-line incision in sixteen cases, right rectus incision in seven cases. In two, both mid-line and McBurney incisions were required, whilst in one other right rectus and McBurney incisions were necessary for the removal of the appendix.

In a case with a mass adherent to the anterior abdominal wall of the right iliac fossa, the caecum was opened into in mistake for the peritoneum, but with no ill effect.

Drainage was required in forty cases. In two cases the appendix was simply shelled out from its thickened peritoneal covering. Whole rubber tube drainage was almost invariably used.

*Typhlitis.*—Cases with much inflammatory thickening of the caecum were met with, and four of these are worth noticing.

One patient, a man, aged 47, with many attacks, had an appendix lying on the ventral aspect of the caecum, with a small loculus of pus. The caecum was greatly thickened, and extended along the ileum for 12 to 15 cm. His age suggested malignant disease rather than tuberculosis.

A short-circuiting of the ileum to the sigmoid was performed, and he is at present well and at work. Microscopic examination of a section from the caecum disclosed chronic inflammation.

A second man, aged 30, had symptoms for one day only, but a mass was felt in the iliac fossa. The appendix was inflamed, but the caecal and ileal walls were very thick and œdematous, with enlargement of the glands in the mesentery. Caecotomy revealed no ulceration, and again microscopically a section showed chronic inflammation. The patient was suffering at the time from secondary syphilis!

A third patient, aged 21 years, had pain 14 days previously, which persisted and passed from the umbilical to right iliac region. Apart from this attack, he was perfectly well. A large, firm mass could be felt, and at operation a partial caecectomy, as well as an appendicectomy, were performed. Large, stony masses of glands extended along the mesentery and appeared to be definitely tuberculous. The pathologist reported again "chronic inflammatory, not tuberculous." The thickening has subsided, though the enlarged glands can still be felt through the abdominal wall.

The fourth patient, a lad, 19 years of age, was struck by a football in the lower region of the abdomen three weeks previous to admission. He had remained in bed for a week following this, on account of pain and soreness in right iliac fossa, but resumed his work at the end of that time. A week before admission the pain returned and a large mass appeared in the right iliac fossa. At operation the appendix was found to be retro-caecal and gangrenous, the caecal walls were greatly thickened and friable and the ileum was fixed to the right lateral wall. There was no hæmatoma present, though it would appear that the injury from the football had produced contusion of the caecum and had led to the appendical attack and the concomitant thickening.

*Deaths.*—There were three deaths in the seventy-five cases of appendicitis—4%; two in males and one in a female. The duration of the acute illness prior to operation in the fatal cases was respectively seven days, three weeks, and sixteen days.

One man was aged 87 years, and was admitted with the diagnosis of acute intestinal obstruction. He had a well-marked general peritonitis from a gangrenous perforated appendix. He had had repeated turpentine enemata before admission, and one in hospital, and on coming out of the anæsthetic vomited large quantities of turpentine-smelling fluid.

The other male patient had a gangrenous appendix lying against the mesentery, with gangrenous patches on several coils of small intestine in the mesentery (? septic thrombosis), and peritonitis. He died on the third day with symptoms of septic pneumonia.

The female patient, aged 37, had been under treatment for gastritis for sixteen days. There were complained of colicky epigastric pain, vomiting and diarrhœa. The pain radiated from the epigastrium to the left loin. She was very obese, slightly jaundiced, with a temperature of 37° C. and a dry tongue on admission to the medical ward, and was thought to be suffering from typhoid. The spleen was not palpable, there was no distension, but patches of urticarial rash were present on the arms and buttock. Her temperature rose rapidly to 40.5° C., with rigors, sweats and increased jaundice. A blood smear showed no eosinophilia, and only a relative polymorphonuclear leucocytosis. The case was thought to be an acute cholecystitis complicating typhoid fever or a suppurating hydatid, and operation was immediately advised. On the upper abdomen being opened, the liver was found to be intensely red and congested and the gall-bladder tense, but not inflamed. The abdomen otherwise was quite clear and the appendix looked for, but not found, the caecum appearing normal to sight and feel. The gall-bladder was drained, but only clear bile discharged and the ducts and

pancreas were normal. The patient was extremely ill, but lived till the fourth day. At autopsy the abdomen was found quite clear, and it was not until the peritoneum was incised to expose the right kidney that a retro-caecal, retroperitoneal, gangrenous appendix was found, accounting for the severe septic type of illness.

*(To be continued.)*

## Reports of Cases.

### A CASE OF URETHRECTOMY.[1]

By **Howard Bulloch, M.B., Ch.M. (Syd.), F.R.C.S. (Eng.), B.Sc. (Oxon.),**

*Honorary Assistant Surgeon, St. Vincent's Hospital, Sydney; Honorary Assistant Surgeon, Sydney Hospital; Senior Surgeon, Renwick Hospital for Infants, Sydney.*

The case I wish to put before you is that of a man, D.B., 56 years, who ruptured his urethra by a fall four years ago. He was operated upon in the country soon after the accident, and a few months later was again operated upon in a private hospital in Sydney. He came to me for operation for double inguinal hernia, but I informed him any operative procedure for the hernia would be useless unless the stricture were cured, as the constant straining on micturition would probably undo the repair made. I found that he had a stricture of the urethra which would not admit more than a filiform bougie, and externally in its vicinity a large mass of firm, fibrous tissue could be felt. He told me that if the stricture were not dilated every week he got retention of urine. After much persuasion he consented to operation upon the urethra.

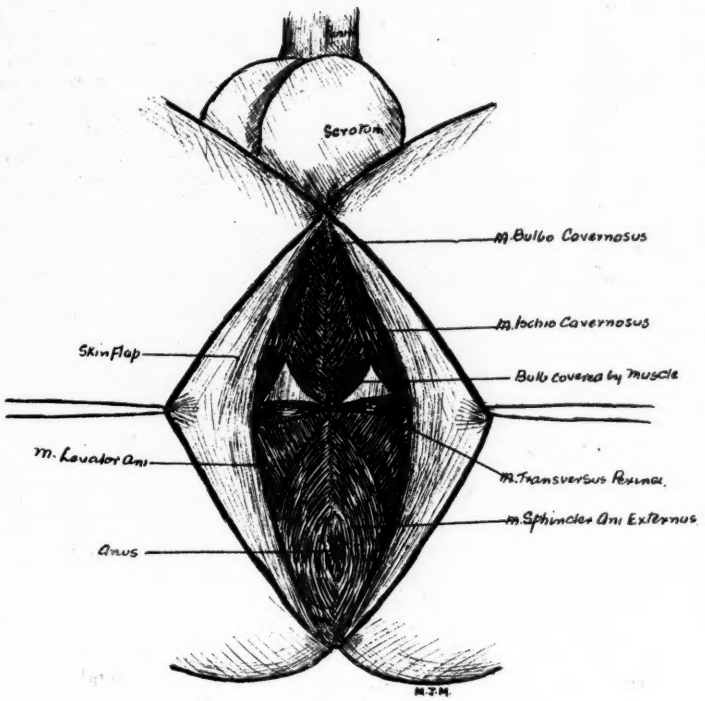


Figure I.

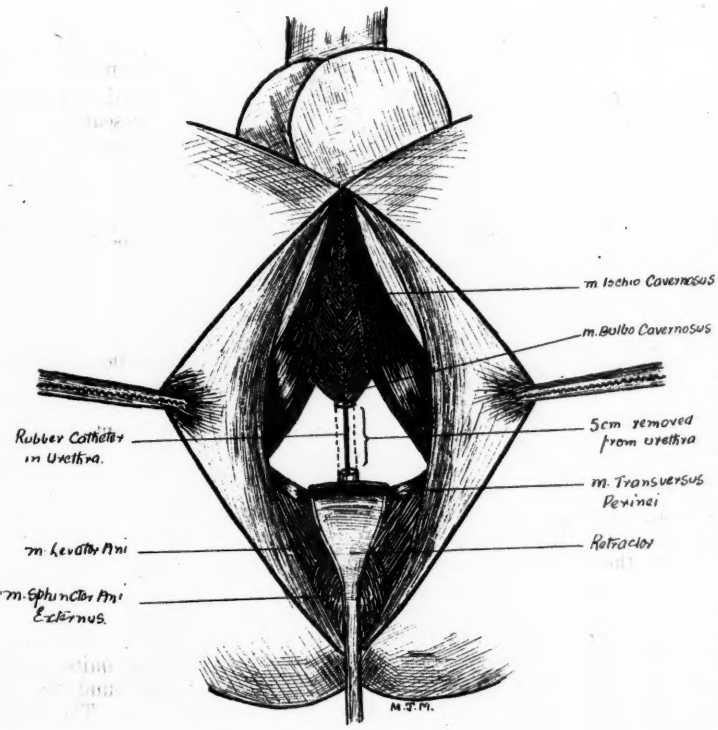


Figure II.

In November, 1917, at Sydney Hospital, with the help of my House Surgeon, Dr. Saxby, I removed 5 cm. of his urethra. The stricture involved the bulbous part of the spongy and membranous urethra. These structures were represented by a large mass of fibrous tissue with a tunnel through it—the urethral canal—and were removed.

The *compressor urethræ* muscle was necessarily cut through. The wall of the distal or penile portion of the urethra was considerably thickened, easily dissected out and united to the proximal portion by several catgut sutures going through the urethral wall, except the mucous membrane.

The distal portion was kept free of tension by three fishing-gut sutures passed through the skin and deep tissues obliquely taking up the urethral wall, except the mucous membrane.

When these sutures were tied they relaxed the distal urethra. The catheter was tied in, the perineal wound sewn up without drainage and the bladder irrigated every four hours. On the tenth day the catheter was removed, the perineal stitches were taken out on the fourteenth day. A $\frac{13}{16}$ in. sound was passed with ease.

The accompanying drawings, for which I am indebted to Mr. McKillop, give a diagrammatic representation of the operation.

The operation of urethrectomy was first performed at the

[1] Read at a Meeting of the New South Wales Branch of the British Medical Association on October 11, 1918.

beginning of the nineteenth century. König used it again in 1882. Since 1891 it has been practised by various surgeons in England, France, America and Germany. The greatest length removed is 8 cm. (3¼ in.), by Goldmann. Keen insists that, if more than 25 mm. are removed, the ends cannot be approximated, and that it is almost impossible to introduce sutures through the superior wall. König united the superior wall only.

Nogues insists on the necessity of preserving the roof of the canal intact, in order to avoid the springing apart of the ends of the canal, which they do if divided. He also advises complete closure of the perineal wound, which he considers essential to a good result. Thomson Walker suggests a preliminary cystostomy and drainage a week before operation and drainage for eight days afterwards. Bramann, Mickulicz, Braun, Socin, Lauenstein and Guyon all united the circumference of the outer wound, with the exception of an opening left for drainage.

The case before us is interesting in several respects considering the opinions of the above authorities.

Chronic cystitis was present, and no preliminary cystotomy was done although urinary antiseptics were given and the bladder irrigated with weak silver nitrate solution a few days before operation.

The stricture was completely excised and the divided ends came together quite easily although 5 cm. had been removed.

The bulbous and part of the spongy urethra were removed, but the distal end of the penis retained its vitality.

No perineal drainage was used and leaving the catheter in for ten days apparently caused no harm.

I might add that since the cure of the stricture he has had the herniæ operated upon.

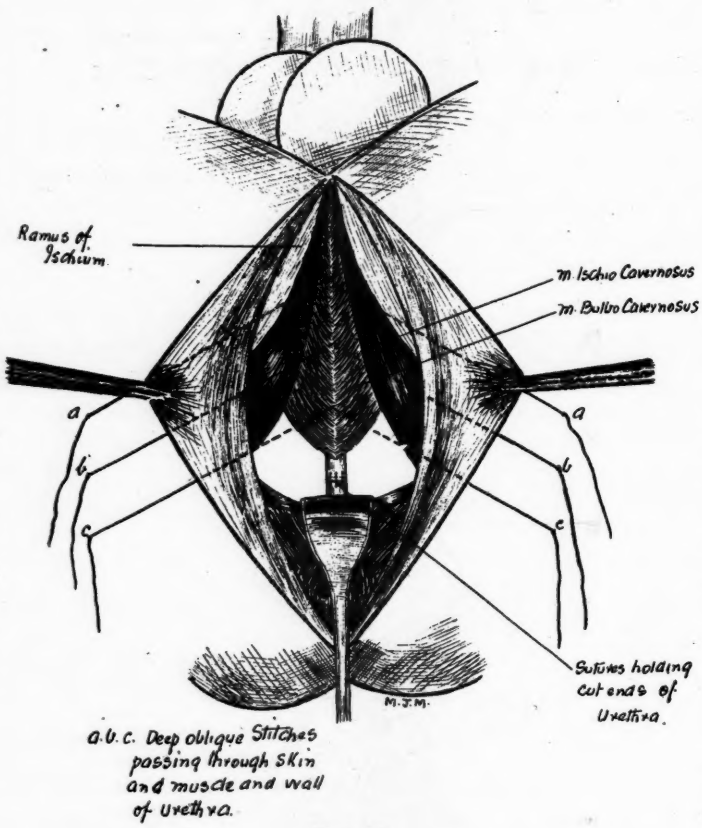


Figure III.

**References.**

Von Bergmann—"System of Practical Surgery," Vol. V., 1904.
Keen's "Surgery," Vol. IV., 1909.
Watson and Cunningham—"Genito-Urinary Diseases," Vol. I., 1908.
Thomson Walker—"Genito-Urinary Surgery," 1914.
Nogues—"*Ann. des Maladies des Voies Génit.-Urin.*," 1892, p. 707.

## CONGENITAL ABSENCE OF LEFT LUNG.[1]

By **A. H. Tebbutt, B.A., M.B., D.P.H.,**
*Chief Resident Pathologist, Royal Prince Alfred Hospital, Sydney.*

I am indebted to Dr. S. A. Smith for kind permission to publish this case.

A boy, aged 12, was admitted to hospital with a history of headaches and pains in the arms and legs for two months.

*Previous Health.*—He had had measles, and had never been strong.

On examination, the right margin of the cardiac dulness was found 1.25 cm. to the left of the sternum and the left margin 15 cm. to the left. There were systolic and presystolic murmurs at the apex. The left side of the chest was dull behind. The X-ray report was to the effect that the heart was enlarged and pushed over to the left side. There were 3,800,000 red cells, whilst the hæmoglobin percentage was reduced to 29, and leucopenia was marked (2,100). The temperature was irregular and intermittent. A terminal diarrhœa supervened and the boy died after one month in hospital.

*Autopsy.*—A thin, pale boy. No œdema of legs. The right lung was bulky, and had apparently pushed the heart to the left side. The pericardial sac was distended with straw-coloured effusion and was adherent to the chest wall on the left side, but not adherent to the right lung. There was no vestige of left lung, the left side of thorax being occupied by the heart, the distended pericardial sac and pericardial adhesions. The upper and middle lobes of the right lung were partially subdivided by vertical furrows and the lower lobe by a transverse furrow. The pulmonary artery gave off a small branch to the upper lobe before entering the lung, whilst the pulmonary vein was formed by the junction of two main branches, which were themselves formed by the junction of two or three smaller veins soon after leaving the lung. The trachea gave off a small bronchus to the upper lobe before entering the lung. In the heart were found a patent *foramen ovale*, malignant endocarditis affecting the aortic valve and a recent but almost healed endocarditis of the mitral valve. The liver was enlarged and fatty and the spleen enlarged. There was a fairly marked ascites was recent infarct in one kidney and also present.

Congenital absence of the lung is a very rare condition, and the difficulties of diagnosis in this case were accentuated by the concurrent malignant endocarditis, apparently of rheumatic origin.

[1] Read at a Meeting of the New South Wales Branch of the British Medical Association on October 11, 1918.

## PERSISTENT THYMUS IN EXOPHTHALMIC GOÎTRE.[1]

By **A. H. Tebbutt, B.A., M.B., D.P.H.,**
*Chief Resident Pathologist, Royal Prince Alfred Hospital, Sydney.*

I am indebted to Dr. G. H. Abbott for kind permission to publish the notes of this case.

A single woman, aged 22, was admitted to hospital com-

[1] Read at a Meeting of the New South Wales Branch of the British Medical Association on October 11, 1918.

plaining of a lump in the throat and palpitation of three years' duration. She stated that she had had typhoid fever at the age of three years. The lump slowly increased in size up to eighteen months ago, then becoming stationary. During the past two months there had been slight dysphagia and dyspnœa. Her two brothers and three sisters were dead. Three had died in infancy.

On admission the House Surgeon noted that the woman was well nourished and not very anæmic. There was a large, bilateral goitre, which was not cystic. She had slight exophthalmos. Von Graefe's sign was positive. There was no tremor. Her pulse averaged 120 and her temperature was subnormal. Both tonsils were enlarged. The heart was apparently clear.

The right lobe of the thyroid gland was removed, a tube being left in for drainage. The patient did not take the anæsthetic well, but was returned to the ward in fairly good condition.

About twelve hours later she became cyanosed, and breathing became shallow and soon ceased. Artificial respiration was at once commenced. There did not appear to be much difficulty in getting air into the lungs, but the cyanosis did not clear up. The House Surgeon heard breath sounds with the stethoscope during artificial respiration. The heart sounds could be heard at first, but ceased later. After an hour artificial respiration was given up. Pituitrin was also given. The temperature, which before operation had been subnormal, rose to 38.3° C. a few hours after the operation, and before death had reached 40.8° C.. The pulse-rate had also increased from 120 to 180.

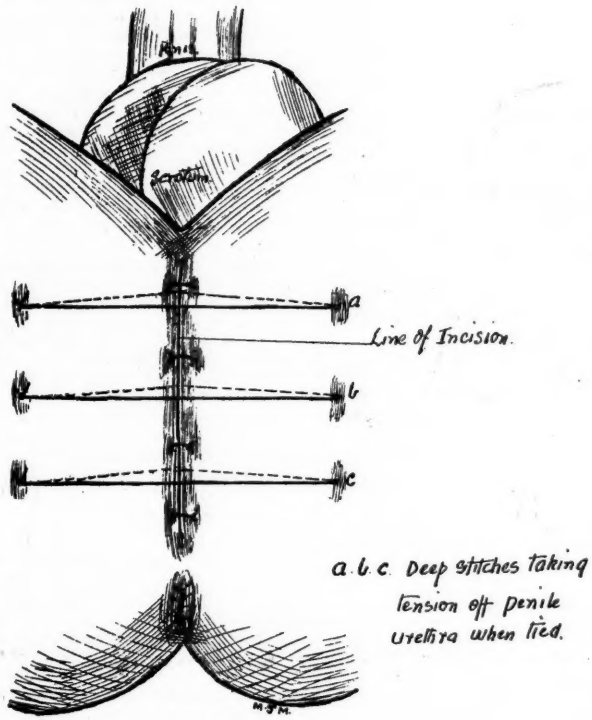


Figure IV.

At autopsy there was found an average amount of subcutaneous fat. There was no excess of blood clot in the wound. The left ventricle showed a slight degree of concentric hypertrophy. The valves were healthy. There was a scabbard trachea. The bronchial glands were enlarged and dark in colour. The mesenteric glands were enlarged, soft and pale. The thymus had persisted, and its maximum dimensions were: vertical, 7.5 cm.; transverse, 6.25 cm., and antero-posterior, 1.8 cm. Its weight after fixation was 25 grammes. Its shape was oval, and there were two conical projections from its upper end, representing probably its original bilateral development from the third branchial cleft. Microscopically I could find no definite pathological variation from the thymus of a child.

The interesting point in this case is the cause and the manner of death. There are three possible explanations: (1) Tracheo-stenosis from pressure of the thymus. (2) Hyperthyroidism. (3) True *status lymphaticus*. If (1) had been the sole cause, one would have expected more dyspnœa than was evident. The cessation of respiration appeared to be due rather to primary failure of the respiratory centre. There was certainly a narrowing of the trachea, but *post mortem* it was not possible to say whether there had been complete obstruction. (2) The marked rise in temperature and pulse-rate after operation are suggestive of thyrotoxic action. Can the failure of the respiratory centre be put down to the same cause? (3) A number of cases of so-called thymic death are on record in which there has been a *status lymphaticus* or *status thymo-lymphaticus*, but no tracheo-stenosis. Death in these cases has been thought to be due to cardiac inhibition, in some cases from pressure of the thymus upon the cardiac ganglia, in other cases from sudden severe peripheral stimuli. The manner of death in this case does not suggest pure cardiac inhibition.

## POLYURIA IN SOME CASES OF MEDULLARY HYPERNEPHROMA.[1]

By **W. F. Litchfield, M.B. (Syd.),**
*Honorary Assistant Physician, Royal Alexandra Hospital for Children; Honorary Assistant Pathologist, Royal Prince Alfred Hospital.*

Some years ago I showed before this Society a case of sarcoma of the skull simulating chloroma. Soon afterwards Dr. Robert Hutchinson reported a collection of eleven cases and showed that the primary growth was in one or other suprarenal gland. In Garrod, Batten and Thurston's book on "Diseases of Children" the condition is described under the title, malignant medullary hypernephroma, no doubt to distinguish it from tumours of the cortex, which give rise to a different symptom-complex. The disease usually occurs in children between two and three years of age, and is characterized by proptosis and fluctuating swellings under the scalp, secondary anæmia and later in the disease by the occurrence of an abdominal tumour. It has to be distinguished from infantile scurvy with orbital hæmorrhages and from chloroma.

I have seen several cases, but wish to report two and refer to another probable one in Australian medical literature, accompanied by pronounced polyuria.

The first was in a boy, aged four years. He was admitted to the Children's Hospital in March, 1910. He had a definite protrusion of the left eye and some fullness in the temporal regions. Subsequently both eyes became proptosed, the swelling in the temporal regions became more pronounced and there appeared fluctuating swellings on various parts of the skull, and he developed polyuria. In May he was passing 13.6 litres of urine in twenty-four hours. The belly was tumid and the liver and spleen could be felt below the costal margins. There were no serious changes in the blood cell count. On May 29 a tumour was felt in the left lower region of the abdomen.

He was seen again in August; the protrusion of the eyes was greater and the swellings on the skull more pronounced. The scalp and abdomen were tender to the touch. He was very thin and still suffered from thirst and excessive urination. He died on September 13, 1910.

In the *Australasian Medical Gazette* of June, 1910, Dr. Cherry, of Tanunda, South Australia, reported a case of *diabetes insipidus* and chronic hydrocephalus. In this case, a girl, aged 2½ years, there was well marked proptosis, a bilateral bulging in the temporal regions and a fluctuating

[1] Read at a Meeting of the New South Wales Branch of the British Medical Association on October 11, 1918.

swelling, with erosion of the bone, on the top of the skull. The child was passing about five litres of urine daily, was anæmic and had a tumid abdomen. It seemed to me probable that this was a similar case to my own.

The other case was that of a girl, aged 2½ years. She lived at Penrith, and came under my notice first in August, 1916. There had been polydipsia and polyuria for three months. At the onset she had abdominal pains and vomiting. She was passing 3.4 litres of clear urine. She had seborrhœa of the scalp, was rather thin, but was otherwise in a fair state of health. She did not have any bulging of the eyes, enlarged glands or tumours of the scalp, but on examining the skull carefully several erosions of the bone were felt, and in one spot over the left parietal bone the pulsations of the brain could be felt. An X-ray photograph of the skull showed a normal *sella turcica*, but several holes in the skull.

Remembering the case mentioned above, although no tumour could be felt, I diagnosed sarcoma of the suprarenal gland. The child returned to Penrith and died in January, 1917. A post-mortem examination was performed

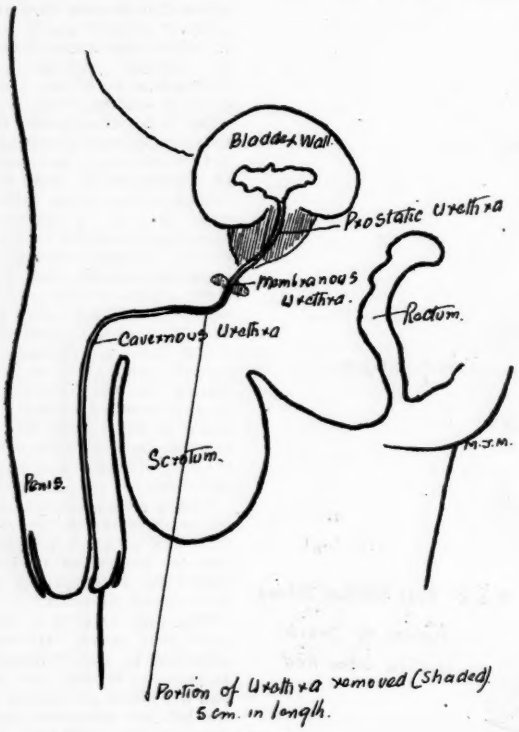


Figure V.

by Mr. Power, ex-laboratory assistant of the Royal Alexandra Hospital for Children, in the presence of Dr. Higgins. A large hæmorrhagic tumour above the left kidney was found, and on deflecting the scalp about twenty areas of eroded bone were found in the skull.

As far as I know, there are no other cases on record of polyuria in this disease. That the symptom is an important one is shown by that in the last case it pointed the way to the diagnosis. The cases are interesting also in showing that there is some relation between the adrenal gland and polyuria.

## Reviews.

### ERRORS OF VISION.

It is a valuable exercise, after some years of practical refraction work, to take a recent text-book and read up the subject *de novo*. For this purpose Ernest Clarke's handbook[1] suits admirably. It is fresh and forcible, it is lucid and readable, and in a justifiable degree it is dogmatic. Here, in the early chapters, one renews acquaintance in the pleasantest way with familiar optical problems, which, though elementary, have an elusive way of escaping one's memory. It is a pity that a mathematical inaccuracy should appear on page 23. The size of the retinal image is inversely proportional to the distance of the object from the eye—not directly as stated; and further this is true only for linear measurements, when we come to speak of the "size of the area on the retina"—this varies inversely as the square of the distance. Each variety of refractive error is described in short chapters. In the treatment of hyperopia in patients up to six years, where the amount is small, equal in the two eyes, and no strabismus present, it is unwise, the author writes, to order any glass. Between the ages of six and fifteen, if the total error is only two dioptres, equal and without astigmatism and strabismus, glasses are not necessary. With these moderate and wise statements we concur heartily, and particularly recommend their consideration to the various educational departments. In the discussion of the causation of myopia, the excessive convergence theory is treated too much as a proven fact, and given undue prominence over the influence of heredity. Full correction of myopia is insisted upon, and the author is convinced of its value in not only checking the advance, but even in some cases in lessening the degree of error. Many of us, however, are less optimistic, and adopt a more fatalistic attitude. The subject of astigmatism and eye-strain is described in considerable detail, and the writer's opinions presented with clearness and force. With the majority of his conclusions we are in agreement, but do not follow him all the way. We know that small astigmatic errors do very often cause symptoms, but so also do larger amounts, and it is difficult to accept his statement that if, in the correction of a gross astigmatism, a small amount is left uncorrected, the eye strain is worse than it was before. Many of us find that patients prefer something less than their full astigmatic correction. Here, theoretical considerations are pushed too far. The benefit derived from wearing proper correction is now universally admitted, and writers are unwise to discredit their specialty by extravagant claims and wild assertions. The author, though evidently an admirer of Gould, is to be congratulated upon the sanity of his outlook.

Two short chapters on heterophoria and squint give the salient features of these conditions. A few hints on spectacles (where Crooke's glass is highly recommended), the vision tests for the services, and an index complete this excellent and stimulating handbook.

### THE DISTINGUISHED SERVICE ORDER.

The revised Statues of the Distinguished Service Order have been published in the *Commonwealth of Australia Gazette*, No. 179, under date of November 14, 1918. The most important provisions are that no person shall be eligible for this distinction who does not actually hold, at the time of his normination, a commission in the Navy, Land Forces or Marines, in the Air Forces or in the Indian or Colonial Naval or Military Forces, or a commission in one of the departments of the Navy, Army or Air Force which entitles the holder to honorary or relative Navy, Army or Air Force rank, nor shall any person be nominated unless his services shall have been marked by the especial mention of his name by the Admiral or Senior Naval Officer commanding a squadron or detached Naval Force, or by the Commander-in-Chief of the Forces in the Field, in despatches for meritorious or distinguished service in the field or before the enemy. The Order is to rank next to the Order of the British Empire. If any person admitted to membership of the Order be convicted of treason, cowardice, felony or any infamous crime, or if he be accused of any such offence and does not surrender himself within a reasonable time to be tried for the same, his name shall be erased from the register of members.

[1] The Errors of Accommodation and Refraction of the Eye and Their Treatment: A Handbook for Students, by Ernest Clarke, M.D., F.R.C.S.; Fourth Edition, 1917. London: Baillière, Tindall & Cox; Crown 8vo., pp. 243, with 93 illustrations. Price, 6s. net.

The Medical Journal of Australia.

NOVEMBER 23, 1918.

## Repatriation.

In the early stages of the war the medical profession had to supply the military authorities with brains and trained individuals, in order that the Australian Imperial Force and the other expeditionary forces might have every advantage from the point of view of hygiene, prophylactic treatment, and prompt medical field service. It is too late to discuss the primary organization or to enquire into the many causes of failure. Too late, and yet too early. After the present task is completed, it will be necessary to set up an Army Medical organization, which shall be directed by men chosen, not on account of long years of having held rank, but on account of organizing ability and keenness of vision.

In the course of the war it became increasingly evident that the Army Medical Corps had a second imperative duty, in instituting the reconstructional treatment, so that the disabled men on discharge from the services might be far advanced in the re-education which war renders necessary. We claim that the demand, repeated for three years and more in these columns, for the establishment of an orthopædic service was acted on only when it became impossible for the authorities to delay any longer. The orthopædic service represented the minimum piece of organization required for the good of our returned soldiers, and of the country as a whole. From the first we have insisted on adequate provision being made for the proper handling of wounded and otherwise disabled men from the moment the permanent nature of the disability is recognized, until human ingenuity can do no more for the individual. We have filled our columns with argument in favour of an intimate co-operation between the military authorities and the Governmental department charged with the duty of looking after the men after their discharge. Hostilities have now ceased, and within a relatively short time 190,000 men will be returning from overseas. It is impossible at present to estimate the number of those who have been disabled, although it is probably that not less than 100,000 will need more or less active medical attention. As will be shown later, a larger number than this will need or should receive some form of professional re-education before being thrown back into civil life. It is useless to complain at this late stage, because the curative annexes to the hospitals are not going concerns, with fully trained medical officers and first-class technologists as teachers, since these annexes are only now being called into existence. Much machinery should have been provided long ago, but since it is still lacking, we must make the best of what we possess. The time for preparation is short, and once the opportunity slips by, it can never be regained. No one will challenge the fact that the workers, who have gone out to fight for the Empire, and who will return shortly, will suffer a serious handicap in competition with their fellow men in all walks of life, unless they are re-equipped for the struggle, and rendered more efficient than before. The men have a right to demand this, since they have given so much. They are coming home different men to those who went forth to see the wide world for the first time. They have come into contact with people with different ideas and ideals; they have experienced things of which the majority never dreamed before; they have taken a sip from the cup of knowledge, and their thirst must now be quenched, at all events, to some extent. The majority of the men went out from unskilled callings. It is true that the greatest need for Australia is agricultural labour, and that this does not entail highly trained brains nor skilled hands. It would, however, be to the advantage to the land-worker if he be given a wider intelligence, and were rendered less clumsy; both a more intelligent interest in the work, and more manipulative dexterity spells greater national efficiency. Some of the disabled will be unfit to return to their previous callings; others will only be able to return to them after patient and skilled re-training. We claim that the obligations of the community is to offer technical training or re-training to every returned soldier and

sailor, and not only to those who have come back physically handicapped. There is a serious handicap caused by the years of excitement, unaccustomed activity and soul-stirring experiences. The psychological effect on nearly every man is very clamant, and it is childish foolishness to overlook it.

The problem of repatriation has thus become a much larger one than the Governmental Department responsible for this work appears to admit. Viewed from the psycho-medical aspect, we do not hesitate to enunciate the thesis that every returning man needs neuro-physical treatment and professional re-education. Viewed from the economical standpoint, it is clear that unless precautions are taken to render every man more efficient in the world of industry than he was before he went out, a time will arrive when he must become far less productive, and in the mass the country will suffer loss. Viewed from the sentimental aspect—who will gainsay the importance of this outlook?—the individual man has a just claim that everything shall be done for him to raise him from his former social level.

Part of the problem encompasses the difficult task of equipping the badly damaged man with technical skill to enable him to compete successfully with his normal compatriots. The task is difficult, but in the vast majority of cases is by no means impossible. We learn of a man whose disability, the loss of an arm, maybe, has plunged him into the seventh world of despair. Instances are met almost daily in our large cities, when this despair is banished as by magic under the sympathetic guidance and expert tuition of a well-trained technologist. The man's outlook is changed as soon as he sees the skilful work of other one-armed men. If anyone has any doubt as to the possibility of a man with one arm acquiring remarkable skill, he should visit the Sydney Technical College, and witness a returned man holding a file in a screw vice attached to an artificial limb, and using it with consummate ease, or see the same man making glass chemical apparatus with the blow flame, using sundry clever devices in the manipulation of half molten glass tubing and rods. If it is possible to teach a child crippled with paralysis and unable to bear the weight of a pencil in its hand, to draw by holding the end of the pencil in the lips, and directing the swung point by the weakest of little fingers, surely there should be but little real difficulty in training a man with a suitable artificial prothesis to become skilled at almost any trade.

If it be admitted that all the maimed and many of the uninjured soldiers on their return from the front should be trained to some special trade, it becomes quite essential to recast the plan of work to accomplish this end. The orthopædic service must serve as the starting point for the work. The sooner the wounded man is subjected to its care, the better for the individual. It may still be possible to equip the transports carrying these men back to the Commonwealth with orthopædic appliances, and to staff these ships with a sufficient number of medical practitioners, who have trained themselves in some recognized orthopædic hospital. Once the men reach Australia, they will pass into the military hospitals, and, when necessary, will come under the care of the large staff, now in course of selection, under Lieutenant-Colonel R. D. Wade. Others will apply for their discharge without having to go to hospital. Both in the military hospital and at the barracks, the officers of the Repatriation Department should keep in close touch with the men, and should induce them to submit themselves to some professional re-education. At the orthopædic annex, skilled teachers in the various vocations will work hand in hand with the responsible medical officers. The medical practitioner will direct the treatment, and will determine the form and degree of muscular training needed for the restoration of physiological activity. The technologist will take his instructions from the medical officer, and will translate them into terms of saw cuts and plane strokes.

When the time comes for the men to obtain their discharge from the Army, the Repatriation Department should already have gained their confidence. The organization should be adjusted in such a manner that there is no break in continuity. The existing vocational committees will be needed to keep a check on the men as they pass out of the Army into the training centres. But if the preliminary work has been achieved while the men are still awaiting their discharge, the difficulty of the task of ascertaining the trade that is suitable for the individual will be greatly lessened. Just as it is essential in the orthopædic

service for a highly trained orthopædic surgeon to be responsible for the organization and for the working of the service, so in the re-education service there should be a technologist, the most expert available, engaged to undertake the whole responsibility for the Commonwealth. In each State there should be a chief technologist, responsible for the work in his re-education school, and under him there should be a staff of competent trained teachers, each engaged in dealing with one vocation or trade. But the parallel with the orthopædic service does not cease here. In the latter, the orthopædic surgeon is in full charge, and has as his lieutenant or assistant a skilled technologist, a man drawing a salary of about £600 a year. In the re-education school the technologist is in full charge, but should have the continuous assistance of a skilled orthopædic surgeon, to guide him in the development of physiologically rescued muscles. It would probably be advantageous for this medical officer to be supplied to the Repatriation Department by the Department of Defence, since the orthopædic service would have commandeered the most highly trained orthopædic surgeons. There is an indication that some co-ordination is about to take place between the Repatriation Department and the Department of Defence. We venture to hope that the principles of this co-ordination will be those involved in the suggestion roughly sketched above.

## THE TALGAI SKULL.

Thirty-four years ago a man, employed in fencing upon Talgai Station, noticed what he thought to be a curiously shaped stone projecting from the bank of a water-course. After dislodging it from its bed he observed that it was a skull. Presented by its discoverer to the owner of the station, it passed into the hands of Mr. E. A. Crawford, from whom it was purchased in 1914 by the Honourable Joynton Smith, M.L.C., who generously presented the skull to the University of Sydney. In 1914 the aged discoverer of the skull was able to take Professor T. W. E. David, F.R.S., to a place within a few yards of which the skull was unearthed. This spot is situated on a "billabong" of Dalrymple Creek, a tributary of the Condamine River which flows into the Darling, and lies about forty miles from the town of Warwick, in Southern Queensland. In the year 1884 heavy rains occasioned a flood, which washed out the channel of the water-course. As the flood subsided the skull was found lying in the wall of the "billabong," about three feet above the bottom, by the fencer, who was traversing the freshly-shaped channel which had been opened in the flats along the course of the Creek. In this area of the Darling Downs the alluvial flats show a superficial layer of six or seven feet of pure black soil, covering a deeper layer of red-brown clay, containing white lumps of carbonate of lime. The skull was apparently found at the upper margin of the clay. Although no bones of extinct animals have been found at Dalrymple Creek, large numbers of bones of extinct marsupials, as *Diprotodon, Nototelephas, Nototherium* and *Megalania,* have been unearthed in similar flats in the Darling Downs. The bones found in the black soil are blackened, while those taken from the clay are light in colour. The incrustation on the Talgai skull has no trace of blackness about it.

The skull was described at the meeting of the British Association for the Advancement of Science in Sydney, in August, 1914, by Professors T. W. E. David and J. T. Wilson. As the geological evidence of the age of the skull was inconclusive, the investigation of the anatomical features of the skull became of great importance. Professor J. T. Wilson had made some dioptographic tracings, and had commenced a detailed study of the construction of the skull when the pressure of military service caused him to relinquish his anatomical work. With great unselfishness he gave the skull to Dr. Stewart A. Smith, who subjected the skull to a careful examination, and published an account[1] of the structure of this fossil skull.

In the undeveloped fossil the cranial and facial portion of the skull were apparently complete, although the mandible was missing. The skull was incrusted with a mineral covering of carbonate of lime, coloured with iron. The cranial cavity contained an earthy deposit, which made the fossil heavy. When the skull had been divided along the median plane, and this incrustation had been removed, it was noted that the skull had undergone much injury. The skull could, however, be recognized as that of a male youth of some fourteen or sixteen years. There had been extensive fracturing of the skull, which had become highly fossilized. The right side of the cranium showed a fracture extending from the base of the skull to the region of the sagittal suture. The left side had suffered less gross injury. The *foramen magnum* was so injured that its entire contour was lost. In addition, all the cranial bones were brecciated so that their condition resembled a coarse mosaic in which the bony fragments were held in position by thin layers of matrix.

As far as the cranium is concerned, comparison of the contours of the left side with those of the skull of a modern Australian aboriginal showed no marked differences. The Talgai brain-case is identical in its general outlines and proportions with many of the crania of modern Australian aboriginals. In the face prognathism is marked. The forehead is sloping in character with poor supra-orbital development. The orbit is large. The premaxillary region is broad and square. It protrudes forwards and slightly downwards from the nasal floor. The canine ridges are far apart. These features, reminiscent of the condition in anthropoid apes, account for the primitive appearance of the face, and, in conjunction with

[1] *Phil. Trans.*, London, Series B., Vol. 208, p. 351, April 6, 1918.

characters of the palate and teeth, are the most significant anatomical features of the skull. The shape of the palate is of primitive type. The area of the palate is greater than in other human skulls. The teeth present are the two canines, two left premolars and the first and second molars of both sides. The crown of the medial left incisor tooth remains. The size of the canine teeth is enormous. The measurements showed that, in some respects, the Talgai right canine tooth is the largest yet recorded. Its shape is human. From a study of the facets on the canine teeth it would appear that the crown of the upper canine projected for nearly seven millimetres below the mesial margin of the upper premolar teeth.

This fossil skull of a not yet adult Proto-Australian presents, therefore, a cranium similar to that of the aboriginal of to-day, but combined with a facial skeleton, in which are found characters more ape-like than have been observed in any living or extinct race, except that of *Eoanthropus*. The discovery of this skull and the establishment of its high geological antiquity affords the first convincing evidence of the presence of man in Australia in pre-historic days.

## THE WELFARE OF MOTHERS AND BABIES.

One of the reasons why the affairs of State are so frequently mismanaged is that in our refusal to recognize the economic value of science, we place at the head of the several departments of government men who may have had technical training in some other field of activity, but have had none in that branch to which they are appointed. It is little surprising that the same fundamental mistake should be made in the popular endeavour to handle sociological problems. On November 4, 1918, a large meeting was held at the Town Hall, Sydney, for the purpose of inaugurating a society for the welfare of mothers and babies. The Lord Mayor presided, and Her Excellency Lady Davidson occupied the post of honour. The business of the meeting consisted in the passing of a resolution to the effect that those present pledged themselves to support the Society in its work for the preservation of child life, in the election of a large executive committeee, with His Excellency the Governor of New South Wales and Lady Davidson as Patrons, the Honourable S. R. Innes Noad, M.L.C., as President, seven Vice-Presidents, and representatives of the Government, of the New South Wales Branch of the British Medical Association, of the Australian Trained Nurses Association, of the Day Nursing Association, of the Royal Alexandra Hospital for Children, of the Kindergarten Union, of the Sydney Hebrew Ladies' Maternity Home and Benevolent Society, of the Foundling Home, of the St. John Ambulance Brigade, of the Health Society of New South Wales, and of the Women's Hospital, as members, and in the passing of another resolution to the effect that a babies' week should be held within a short time.

The newly formed Society proposes to establish baby clinics, under the charge of a fully trained nurse. An endeavour is to be made to obtain the honorary services of one or more medical practitioners to advise the nurse in regard to the infants "who cannot be safely treated in the home." In the next place, it is proposed to give a course of training to young women of from 18 to 25 years of age, in the management of infants. The training would include practical work at the clinic, attendance at lectures on infant hygiene and the like, and attendance at the Infants' Hospital. After one month the young woman would be allowed to carry out district work, under the guldance of the trained nurse of the clinic. After six months the pupils would be examined and, if successful, they would obtain certificates "as being qualified to undertake positions as nurse-maids or mother's helps of a highly trained and reliable type." At each centre it is suggested that the mothers and their infants will be examined by the medical practitioner, if necessary. It will be noted that a very large gathering of intelligent citizens, headed by the Lord Mayor, and including medical practitioners of high repute, seriously accepted these proposals as a solution of a difficult social problem, the high infantile mortality. History contains some records of a successful endeavour to diminish infantile morbidity and mortality, but in every one of these cases, the institution undertaking the localized campaign has been directed by a medical practitioner, trained not for six months, but for many, many years, in the physiology of the infant, and in the pathology of its ailments. The names of Budin and Eric Pritchard may be quoted to show that the active co-operation of the expert is essential if any appreciable headway is to be expected. The scheme of the Society for the Welfare of Mothers and Babies places the differentiation between a disturbance of physiological processes by faulty environment, and an invasion of the organism by some pathological process in the hands of a trained nurse, with the possible occasional advice by a medical practitioner, who is generous enough to place his services at the disposal of the Society without remuneration. Moreover, there is an implication that the young woman with a very brief and hopelessly inadequate training should be trusted to direct mothers in the management of weakly and possibly ill babies. It is impossible to imagine a more risky procedure, for the work of ministering to mothers and babies is extremely difficult work, needing much knowledge, discrimination and previous experience.

## THE CULTIVATION OF MEDICINAL PLANTS.

Man found the remedies on which he depends for the restoration of his health, among the familiar herbs and weeds growing in the woods, fields and hedgerows around him. Even at the present time the supplies of the materials needed for the manufacture of the pharmaceutical preparations of many drugs are collected from wild plants growing in different districts of Europe. The roots, herbs and flowers are sought, picked and dried by those who have received from their forefathers information as to the appearance of the plant when ready to be gathered. This herbal lore is the accumulation of centuries of experience, and is by no means widely known. In any

single district only a small number of plants can be collected for the world's marts.

The interference with the transport of merchandise, occasioned by the war, has led to more attention being paid to the cultivation of medicinal plants for commercial purposes. Already some attempts had been made to grow plants of medicinal value. In the United States the Institute of Industrial Research, Washington, D.C., has devoted much research to ascertain the conditions under which the commercial cultivation of the drugs in common use could be undertaken. These drugs include aconite, belladonna, digitalis, henbane, rhubarb, senna, gentian, golden seal, senega and ajowan seeds. From these drugs high priced alkaloids and glucosides are, in some cases, separated.

Though there is a market for all these drugs the need is strictly limited, and any over-production is either unsaleable or saleable at a price less than the cost of production. While European supplies are collected from wild plants by cheap labour, the growth of medicinal plants in farms in America requires the employment of highly priced labour. It has become necessary in many cases to increase the amount of the valuable active constituent in the plant, in order that its value may compensate for the higher cost of cultivation. In the United States it has been found that the belladonna plant can only be grown with profit when the dry plants contain twice the amount laid down for the assay of the Pharmacopœia.

By careful selection of the seed it has been possible to increase the amount of active constituents in such plants as belladonna and digitalis to four times what the Pharmacopœia requires. By better methods of harvesting, as many as three or four crops can be obtained in a season, instead of one or two. Assays have shown at what period of growth the plants should be gathered, so that they yield the greatest amount of active constituent. Investigation has revealed methods of drying, which conserve the active principles. All these matters are of such importance that the cultivation of medicinal plants will be most probably reserved for a few expert horticulturists familiar with the numerous details of cultivation.

## THE INFLUENZA EPIDEMIC.

A special Bulletin of the Quarantine Service has been issued, dealing with the salient facts concerning the outbreak of influenza in various parts of the world. A mild type of this disease appears to have been prevalent in many countries since May, 1918. In September influenza attended with an alarmingly high mortality was said to have been prevalent in Spain and also in Germany and Austria. Serious outbreaks were also reported in parts of the United States of America. During the second week of October a very severe epidemic of so-called influenza was reported in the daily press as occurring in South Africa. Enquiries by cable elicited the information that the microorganisms isolated were Pfeiffer's influenza bacillus, a streptococcus and the *micrococcus catarrhalis*. The disease was characterized by the frequent complication of pneumonia, and was stated to be highly infectious and very virulent to white persons. Pfeiffer's organism had not been discovered in the United States.

On October 12, 1918, the *Niagara* arrived in Auckland with 100 of the passengers and crew affected. One death occurred from broncho-pneumonia. On October 16, influenza or any febrile, toxic or septicæmia condition similar to influenza, was proclaimed a quarantinable disease. South Africa was proclaimed a country infected with influenza, and entry into Australia from South Africa was limited to the ports of Fremantle, Adelaide, Melbourne, Sydney and Brisbane. Instructions were given to ensure the proper carrying out of quarantine measures of all persons coming from South Africa, and the prophylactic spraying in a suitable chamber, as prescribed by the British Army for the prophylactic treatment of meningococcal carriers, was introduced.

On October 18, the *Mataram* arrived at Darwin from Singapore with 58 persons suffering from the disease on board. One of these persons died. Two days later the *Charon* arrived at Broome from Singapore with 17 persons infected. One of them died. On October 22, the *Australrange* arrived at Adelaide; on October 26, the *Australcrag* arrived, and on October 28, the *Juno* arrived. Precautionary measures were adopted notwithstanding the fact that no definite cases of influenza were notified. Seven persons infected with influenza arrived on board the *Carina* at Fremantle from Calcutta, on November 4, and on the following day the *Tango Maru* arrived at Sydney from Japan with ten passengers infected. One of them died.

It was reported on October 26, that some nurses had been infected at the Auckland Hospital by patients from the *Niagara*. The disease spread beyond the Auckland Hospital, possibly through the agency of labourers from Europe. In the milder epidemics prevalent in Europe in June and July *micrococcus catarrhalis, pneumococcus,* a *streptococcus* and a Gram-positive *diplococcus* were found repeatedly, but the Pfeiffer organism was apparently not present. The same four bacteria have been found by the staff of the Commonwealth Serum Laboratories from recent cases of the milder type in Australia. The microbiologist of the Department of Public Health of New South Wales and the bacteriologist at the Sydney Hospital stated that they had isolated the Pfeiffer bacillus from Australian cases, but cultures apparently have not been preserved. It is stated that the influenza bacillus is primarily responsible for the fatal form of the disease in South Africa, while reports from the New Zealand Health Department indicate that this bacillus has been isolated from the severe cases in passengers on board the *Niagara*.

The principal clinical features of the disease, as described by Surgeon-General Blue, of the United States Public Health Service, are enumerated. The onset is sudden, a rigor is soon followed by high fever, reddening and running from the eyes, pains and aches all over the body and general prostration. The same authority states that the secretion from the nose, throat and respiratory passages form the sources of infection. The incubation period is from one to four days, and the infection is transmitted by direct or indirect contact, and also by droplet spraying.

According to the South African authorities some patients do not have either fever or catarrh. They state that the disease seems to be essentially septicæmic, while intestinal, meningeal and aural complications are met with. There is little doubt concerning the value of vaccines for the prevention of serious complications. The South African authorities have cabled that the value of a mixed vaccine in preventing serious complications has been increasingly evident. A mixed vaccine can be obtained at the Quarantine Officer in each of the capital cities.

Mr. Justice Ewing has been commissioned to hold an enquiry into two matters in connexion with the charges brought by the Tasmanian Branch of the British Medical Association against Victor Richard Rattan. These matters are whether the Harvey Medical College existed in Chicago in 1907, and whether the diploma which Victor Richard Rattan produced in Tasmania in 1907, was granted to him by the Harvey Medical College. The reference to the Royal Commissioner does not cover the point raised by the Tasmanian Branch, that the alleged diploma was not a document certifying that Victor Richard Rattan went through the prescribed course of medical study and passed an examination entitling him to practise medicine in the country of origin.

Dr. William Thornborough Hayward, C.M.G., has been appointed a member of the South Australian Medical Board.

# Abstracts from Current Medical Literature.

## OPHTHALMOLOGY.

### (171) The Diagnosis of Sympathetic Ophthalmia.

S. R. Gifford reports the result of a differential blood count in nine cases of true sympathetic disease, six cases of recent perforating wounds of the globe, and eleven cases of prolonged non-traumatic inflammation of one eye (*Archives of Ophthalmology*, July, 1918). The literature on the subject contains conflicting views. Gradle reported an increase in mononuclear cells to 40% in six cases of irido-cyclitis, where there was danger of sympathetic ophthalmia. This increase dropped to normal after enucleation of the injured eye. Ormonde, Browning and Price-Jones reported similarly, and found that the count approached normal after salvarsan had been given. Other observers discredit these findings. In the author's nine cases of sympathetic ophthalmia he found an increase of mononuclear cells of from 53% to 33% above the normal, especially in the large mononuclear cells. The count did not change materially under treatment or after enucleation. In the second group (perforating injuries) the average mononuclear count was 30%. In the third group (chronic inflammation) the mononuclear count varied from 30% to 46%—average 35.1%. Three counts made on the author himself average 49.7%; at other times counts on himself were normal. The writer concludes, therefore, that an increase in mononuclear cells is met with in sympathetic ophthalmia, but that it is not specific or constant or of any value in diagnosis.

### (172) Focal Infections of the Eye from the Intestinal Tract.

J. G. Dwyer publishes a preliminary report on investigations extending over two years of eye infections due to absorption of toxins from the intestinal tract (*Archives of Ophthalmology*, May, 1918). The intestinal contents were examined as to their reaction (which should be faintly acid), their content of indol and skatol, the food residue, and the bacteria. In most of the patients examined the contents could be classified under two headings: as to whether they were highly acid or alkaline. In both such classes the colon bacilli were either entirely absent or few, the other bacteria being Gram-positive and ptomaine producing. In the highly acid and highly alkaline specimens indol and skatol contents were high and a large percentage of indican was found in the urine. In the highly acid cases treatment was directed to alkalinize the contents by irrigation of 1% sodium bicarbonate solution, colon bacilli transplantation, and restriction of meat diet. In the highly alkaline cases irrigations with sugar of milk were given and colon bacilli transplanted, and Bulgarian bacilli given by mouth. Examinations were made at intervals until a good growth of colon bacilli was found. Sixty-seven cases were satisfactorily treated on these lines. Previous treatment of the teeth and tonsils had in many cases proved unavailing.

### (173) Active Anterior Ethmoiditis in Young Subjects.

Sydney Stephenson regards acute anterior ethmoiditis as "tolerable common" in young children; it is usually described as orbital suppuration, and the underlying factor is often unrecognized (*Brit. Journ. Ophthalm.*, August, 1918). Some of the milder cases get well with simple or no treatment, with or without a discharge of pus from the nose or pharynx. The disease is unilateral, attended by fever and malaise, but not followed by intra-cranial complications or optic atrophy. The author's rhinoscopic examinations have "amounted to very little." In severe cases it is usual to incise the orbit over any pointing spot. Pus may not escape at the time, but later. The writer now makes a curved incision over the inner angle of the orbit and introduces a raspatory beneath the periosteum over the anterior ethmoidal cells, when pus usually escaped. Ten cases are described, selected from a large number. The first case is regarded as typical. A boy of two years developed without known cause inflammatory œdema of the lids of one eye. The globe was pushed forwards and outwards. The child was semi-conscious, with a temperature of 40.5° C.. A deep incision was made through the centre of the upper lid into the orbit, dressing forceps were introduced, and a small amount of pus escaped and continued discharging for some days. This child, curiously enough, developed temporary amaurosis in the affected eye.

### (174) Disturbances of Vision by Cerebral Lesions (Occipital War Injuries).

Gordon Holmes is able to produce fresh material to confirm his previous findings, namely: (1) The upper half of each retina is represented in the dorsal, the lower in the ventral part of each visual area. (2) The centre for the macula lies in the posterior extremity of the visual areas. The macular region has not a bilateral representation. (3) The centre for the periphery of the retinæ is situated in the anterior ends of the visual areas, and the serial concentric zones of the retina from macula to periphery are represented in the visual area from behind forwards (*Brit. Journ. Ophthalmology*, July, 1918). The most instructive cases are those with central and paracentral scotomata. Thus, in cases of inferior paracentral scotomata from occipital injury, the lesion involved the margins of both occipital lobes, above the level of the calcarine fissure. With superior paracentral scotomata it was the part below the calcarine fissure that was involved. Other problems are suggested by sector scotomata, and though, in the absence of definite localization of the lesions, the conclusions have the value only of probable hypotheses, these cases seem to show that the vertical radii of the retinæ have their centre in the exposed calcarine cortex and the horizontal radii have their radii in the walls and floor of the calcarine fissure. Cases of injury to the optic radiation support these views, lesions of the lower radiations producing superior quadrantic hemianopsia, and lesions of the dorsal radiation, inferior horizontal hemianopsia. Total destruction of a portion of the visual area produces permanent loss of sight in the corresponding parts of the field, but part of the visual defects observed early, which is temporary, is due to the surrounding local concussion and œdema. Parietal cortical lesions may cause disturbances of the higher visual perceptual functions, as loss of visual orientation, loss of perception of depth and distance, visual attention loss, and visual agnosia.

## LARYNGOLOGY AND OTOLOGY.

### (175) Ear, Nose and Throat Diseases Amongst the Australian Troops in Egypt.

J. W. Barrett (*Journ. Laryng., Rhin., Otology*, April, 1918) states that large numbers of men were found to be suffering from chronic otorrhœa, with foul discharge, enlarged tonsils, adenoids, nasal obstruction and sinus disease, contracted before enlistment. In addition, there was a steady inflow of cases contracted on service. A feature of the cases of acute otitis was the severity of the attack. Cases of measles and broncho-pneumonia were frequent. Considerable exhaustion followed the attacks. Adenoids were very prevalent, probably due to the irritation from the desert dust, laden with organic matter, and to the severe colds from which the men suffered. *Otitis externa*, usually associated with otorrhœa, was not uncommon. Numbers complained of deafness due to shell-shock. Most of these proved to be unilateral and due to gunfire. In some cases the membrane was ruptured. Bilateral cases of concussion deafness were almost invariably cases of hysterical deafness, and underwent remarkable recoveries under rigid treatment, especially after faradization through the mastoids. A small percentage of cases of feigned deafness was met with. In these discrepant responses were made to tuning-fork tests, bandaging the eyes and testing the hearing at different distances from unknown sources of sound, and other devices. Septal spurs and deviations were not corrected, but post-war treatment advised. As regards fitness for service of men with some degree of deafness or with chronic otorrhœa, the author holds that, in the latter case, the patient should be instructed in cleaning the ear and medicating it with drops of a solution of equal parts of methylated spirit and 5% carbolic acid, which he is called upon to carry out daily, and, after the removal of polypi or granulation tissue, he

should be sent back to work. Remarkable results were thus obtained, for often chronic *otitis media* with foul discharge of long standing was cured in a few weeks. A moderate degree of deafness permits a soldier to do all duties but sentry work, and such as he should be usefully employed in the Army. Aural work constituted two-thirds to three-quarters of the aurist's duties, and of the aural diseases the infective group, furunculosis and chronic *otitis media* comprised at least two-thirds. Nasal, pharyngeal and laryngeal diseases, apart from diphtheria and tonsillitis, constituted a third to a quarter of all cases.

### (176) Stefanini's Phonometer.

In the July, 1918, number of the *Journ. of Laryng., Rhin. and Otology*, D. Gradenigo, of Naples, describes an instrument devised by Stefanini, by means of which the auditive power of an individual may be measured. For the unit of sound, that corresponding to a definite mechanical energy is assumed, *e.g.*, the microjoule = 10 ergs, which is transformed into sonorous energy when two spheres strike. The auditive power within a zone in which sound is audible is recorded in "phonies," which the machine is adapted to measure absolutely. Gradenigo substitutes for one of the spheres a varnished cardboard cylinder or "sounder" of such dimensions that it gives off a sound of a certain pitch when struck by a small metal sphere. The former is suspended by four threads, the latter by a very light, thin straw from a horizontal axis, which itself is supported on a vertical bar. The whole is mounted on a little metal tripod provided with a small spirit-level and equipped with screws to enable the machine to be accurately levelled. The tripod is placed on a thick iron slab, the better to isolate the sounds. Gradenigo employs three sizes of sounders, which give off sounds corresponding to the C of 128 vibrations, the C of 512, and the C of 2,048. The intensity of the sound is varied by allowing the sphere to fall through different angles, which are marked on a metal arc fixed to the upright. With the sounder C 2,048 to a person with normal hearing listening at a distance of ten metres in a direction perpendicular to the plane in which the sphere falls, a drop through twelve degrees produces an audible sound. The precision and constancy of the results obtained, the simplicity of the apparatus and its usefulness as a substitute for tests with the voice and for standardizing the voice are its recommendations.

### (177) Decompression Operation on the Hypophysis.

Headache, involvement of vision and perverted pituitary function, plus Röntgenographic findings, such as widening and deepening of the sellar floor, even a shadow outline of the glandular mass, if it has already invaded the sphenoid sinus, a thickening or thinning of the bones at the base of the skull, enlargement or absorption of the clinoid processes, and any increase or decrease of the diaphragm opening, are generally sufficient to establish a diagnosis of pituitary tumour. Otto J. Stein (*Laryngoscope*, May, 1918) recommends operation by the nasal route confined between the two muco-periosteal flaps of the nasal septum. Thereby, he states, rapid and easy trans-sphenoidal access can be obtained to the sellar floor and the gland beyond. The floor of the fossa seems to present the line of least resistance to tumours of the pituitary, but another weak point is the infundibular, which connects the *pars intermedia* with the third ventricle. Along this path cysts are likely to develope. To avoid injury to nerve, artery and cavernous sinus instrumentation should be employed solely in the middle line. The author deprecates systemic anæsthesia as unnecessary, and recommends morphine-hyoscine or scopolamine-morphine, with flake cocaine locally on the septum and sphenoid. A preliminary analysis of the urine for evidence of oxybutyric and diacetic acids and acetone to avoid the possibility of post-operative acidosis is urged. Stein calls attention to the fact that the optic chiasma lies not, as is often taught, in the optic groove, but with its anterior border presenting at the posterior part of the pituitary gland and the optic nerves on either side. The author quotes Cushing to the effect that hypophyseal cysts tend to refill after evacuation, with return of the pre-existing visual defects.

### (178) Shell Concussion Deafness.

The three factors to which shell-concussion deafness is probably due are stated by C. E. Jones-Phillipson (*Journ. Laryng., Rhin. and Otology*, April, 1918) to be: (1) cerebral concussion; (2) over-strain and fatigue of the organ of Corti, the former being due to violent oscillations of the perilymph communicated to the organ of Corti, the latter to continuous violent noises or explosions at close quarters, and (3) temporary or permanent disorganization of the conductive apparatus. The prognosis depends on the recovery of these parts. After severe shocks patients may suddenly become deaf, often dumb, also blind, and may be with paresis in one or more limbs. Here the higher centres are temporarily involved. In a few days, as shock passes off, there is generally a sudden improvement in hearing, and, when the patient is removed from the firing-line, usually an improvement in the nervous symptoms. A portion of the deafness may more slowly disappear as the condition of the internal ear returns to normal. Structural damage in the middle ear must leave a more or less permanent imperfection of function, but shell-concussion deafness is, to a large extent, temporary and curable.

### (179) Paroxysmal Stuttering.

A soldier, after severe shell-shock, was found to stutter badly, a resumption of a condition which had alternated with periods of normal speech since the patient was four years of age, when stuttering first occurred, following a fright. Briand and Philippe (*Progrès Médical*, August 4, 1917) describe the treatment which conquered the impediment in three weeks. It was commenced with breathing exercises, the patient being shown the tracings, and taught how to manage the diaphragm to bring the tracings to normal by training the muscles necessary to regulate the diaphragm functioning. The patient accomplished this control by reading exercises in solitude, slowly uttering the words in a low voice, noting the letters that excited the stuttering, and meeting each with a deeper or more prolonged respiration. Walking slowly about, rather than sitting or reclining, whilst practising the exercises, was found to facilitate the recovery of breath control, whereas strong emotion, over-exertion or exhaustion acted as setbacks.

### (180) Middle Ear Medication per Tubam.

In the treatment of chronic catarrh of the middle ear, especially the exudative variety, Dan. McKenzie (*Journ. Laryng., Rhin. and Otology*, April, 1918) reports good results from the medication of the middle ear, *per tubam*, with the following solution, which he blows through an Eustachian catheter of wide calibre: *iodi resublimat.*, 0.12 to 0.24 gm.; *ol. sassafras.*, 0.06 c.cm.; *menthol.*, 0.18 to 0.3 gm.; *camphoris*, 0.18 to 0.3 gm.; *ol. eucalypt.*, 0.18 c.cm.; *paraff. liq., ad* 28 c.cm.. The solution should be slightly warmed before being used, and given at least once weekly. From experiments on himself he states that three distinct sensations are distinguishable when fluids, such as menthol, are injected through the tube—an Eustachian—a peculiar cool tingling of the cheek and lip of the same side; a tympanic, felt in the area where one gets earache, as well as in the external meatus, and even in the auricle and mastoid, and a mastoid, when clove oil is used.

### (181) Diagnosis of Tuberculous Otitis.

The only positive signs of a tuberculous otorrhœa are stated by M. Lermoyez to be those afforded by bacteriological examination of the pus, a biopsy, and guinea-pig inoculation (*Presse Médicale*, July 26, 1917). Diagnostic tuberculin injection is contra-indicated. The infection occurs by way of the Eustachian tubes, and may be characterized by (1) an insidious onset, (2) paradoxical deafness, *viz.*, marked and rapid loss of hearing, in spite of but slight change in the otoscopic picture, together with extensive variations in the extent of deafness and of facial paresis, (3) pale greyish, firm fungous masses in the tympanum recurring after curettage, and increasing after chemical cauterization, (4) often a very characteristic "white caries" of the walls of the tympanic cavity, attic and antrum, with the production of fœtid, cheesy masses, and (5) a persistent, narrow sinus, lined with fungous outgrowths, representing the incompletely healed mastoid wound, through which a small seqestrum is some time later discharged.

# British Medical Association News.

## SCIENTIFIC.

A clincial meeting of the New South Wales Branch was held at the B.M.A. Building, 30-34 Elizabeth Street, Sydney, on October 11, 1918, Dr. A. A. Palmer, the President, in the chair.

Dr. H. Bulloch read some notes on a case of urethrectomy (see page 429).

Dr. W. T. Chenhall said that some years before he had seen a similar case under the care of another practitioner. He thought that this case might have been treated with advantage in the same way. He referred to the difficulties which he had experienced in his own practice, in dealing with the bladder end of the urethra in females. He thought it would have been interesting if a sound could have passed in Dr. Bulloch's case and X-ray pictures taken of the condition.

Dr. T. Fiaschi congratulated Dr. Bulloch on the success of his treatment of a case of long-standing traumatic stricture of the urethra. He thought, however, that Dr. Bulloch's success in approximating the two ends of the divided urethra had probably been due to the fact that the five centimetres which he had removed, had consisted of interstitial tissue and not urethra proper. It was his practice in similar cases to do a perineal section, and to bring the two ends of the urethra together. The principle was to establish continuity. He would not approve of urethrectomy being done in all cases of stricture.

Dr. W. F. Litchfield referred to the troublesome cases of hypospadias which from time to time were seen at the Children's Hospital.

In his reply, Dr. Bulloch stated that it was not unlikely that Dr. Fiaschi's suggestion, that the two ends of mucous membrane that came together after the excision of the fibrous tissue, were the original ends of the severed urethra.

Dr. A. H. Tebbutt demonstrated a pathological specimen of the congenital absence of one lung (see page 430).

Dr. W. T. Chenhall congratulated the Branch on the excellence of the material submitted to the meeting, and referred in particular to the dissection exhibited by Dr. Tebbutt. He thought that it would be of great value to the Branch if a pathological museum could be established, where specimens shown at meetings could be kept and studied in connexion with reports of the discussions which took place in reference to them.

Dr. T. Fiaschi congratulated Dr. Tebbutt on his interesting demonstration. He referred to the work which had been carried out by Dr. Pietro Fiaschi in the artificial removal of one lung in dogs. He had lately seen one of the dogs from whom Dr. Pietro Fiaschi had removed one lung four and a half years before. The dog was in good health. In the few cases which had been recorded of absence of a lung in human beings, the patients had seemed to have been in a very low condition of health.

Dr. A. A. Palmer said that he had had no experience of the congenital absence of one lung. He had frequently seen cases of complete congenital atelectasis, in which life had persisted for a considerable time. He also spoke of the congenital abnormalities of the heart, and of the pulmonary vessels.

Dr. W. F. Litchfield suggested the possibility that the two lungs had been fused. The specimen appeared to him to indicate that there were several lobes.

Dr. Tebbutt also recorded the details of a case of persistent thymus gland in exophthalmic goitre (see page 430).

Dr. W. T. Chenhall said that he had noted the frequency with which the thyroid gland enlarged in early pregnancy. Since the war had started there had been an enormous increase in the incidence of exophthalmic goitre. He was not sure that the operative treatment of exophthalmic goitre had been a success. He believed that it was a sound principle to stimulate the antagonistic gland, rather than to remove the offending gland. He thought that the administration in some cases of *corpus luteum* or ovarian substance, or perhaps suprarenal gland might be useful. In the male it was possible that testicular secretion could be used with advantage. He had noted in some cases that diminished ovarian activity was associated with hyperactivity of the thyroid gland. As a rule, drugs were in his opinion useless. X-ray treatment, however, was to some extent satisfactory. Beneficial effects also followed the application of galvanic and sinusoidal and high frequency currents over the gland itself, and also over those glands which were thought to be antagonistic, especially the ovary, the mammæ and the adrenals.

Dr. A. A. Palmer was interested to learn from Dr. Tebbutt that the thymus gland continued to increase in weight up to puberty. He had been under the impression that it diminished, not only relatively to the body weight, but in actual weight after two years.

Dr. W. F. Litchfield thought that it was important that the case should be recorded. He held that Dr. Chenhall's suggestion concerning the relation of the endocrine organs was of value. All cases of the kind should be carefully recorded, and when some hundreds of records had been collected, definite conclusions could, no doubt, be drawn from them.

Dr. J. MacPherson said that it was well recognized that the thymus gland was large in many cases of exophthalmic goitre. Anæsthetists were well aware of the danger of handling such cases. If death occurred, it was called "thymic death," or was attributed to *status lymphaticus*. The use of these expressions served no purpose in determining the cause of death. From his point of view the removal of the thyroid in Basedow's disease was illogical. The enlargement of the thyroid was only one symptom. The disease might be present, and all the other symptoms associated, without any evidence of the thyroid being involved. In cases in which portion of the thyroid was excised, the removal of the deformity was the only benefit, except when it was done to relieve pressure on the trachea. In other cases it seemed to him to be just as rational to cut out the rose spots for the cure of typhoid fever as to remove the thyroid in exophthalmic goitre.

Dr. Tebbutt expressed his gratitude for the manner in which the members had received his demonstrations. He drew attention to the fact that there was ample material for clinical evenings at his department, at the Royal Prince Alfred Hospital, and that he would be glad to get specimens ready, if the physicians and surgeons would present the cases from the clinical point of view. In regard to the growth of the thymus gland, he said that it was heaviest, relatively, at birth, but increased actually in weight up to puberty. The maximum weight was probably about 20 grammes. In regard to the term "thymic death," the opinion held at present seemed to be that these deaths were always due to pressure on the trachea.

Dr. W. F. Litchfield read a paper on "Polyuria in Some Cases of Medullary Hypernephromata" (see page 431).

## MEDICO-POLITICAL.

At a meeting of the Queensland Branch, held on September 5, 1918, it was resolved on the motion of Dr. J. B. McLean:—

> That in the opinion of the Queensland Branch of the British Medical Association it is desirable that a properly built and equipped infectious diseases hospital, large enough to cope with all infectious diseases, be established in Brisbane.

The President drew the attention of members to the new Poison Regulations, and dealt with those which affected medical practitioners.

At a meeting of the Queensland Branch, held on October 4, 1918, the correspondence with the Federal Committee, dealing with the proposed Medical Officers' Relief Fund, was considered. It was unanimously determined that the proposals be adopted *in toto*.

On the motion of Dr. E. W. Kerr Scott, seconded by Dr. R. Graham Brown, a sub-committee was appointed to collect contributions for the fund.

Letters from the Federal Committee, dealing with the conditions of medical service to be rendered on behalf of the Repatriation Department in connexion with returned soldiers, were received. It was resolved that a fee be asked for for advice given in connexion with men applying for relief from the Repatriation Department.

Dr. A. Sutton moved that it be an instruction to the Council to make a vigorous protest against the Third Schedule attached to the *Medical Act Amendment Bill* of Tasmania,

and to insist on the introduction of a reciprocity clause. The motion was seconded by Dr. W. N. Robertson and carried unanimously.

A meeting of the Rockhampton members of the Queensland Branch was held some weeks ago for the purpose of discussing with the executive officers of the various friendly society lodges the introduction of the model lodge agreement. The out-lying lodges having an aggregate membership of about 900, accepted the agreement, and approved the new rate of 25s. *per annum*. The Associated Friendly Societies Institute declined to meet the members. This Institute comprises about 1,100 lodge members. Advertisements were published for new medical officers. The words "British Medical Association rates, 25s. per member, paid" appeared in the advertisements. The Institute, in response to an enquiry whether they were prepared to sign the model lodge agreement and accept the conditions set out therein, referred the local practitioners to the wording of the advertisement. Apparently the constituent lodges are not prepared to sign the model lodge agreement. Members of the British Medical Association are particularly requested to communicate with the Honorary Secretary of the Queensland Branch before considering whether they should apply for any positions in connexion with the Associated Friendly Societies' Institute of Rockhampton.

A meeting of the New South Wales Branch was held at the B.M.A. Building, 30-34 Elizabeth Street, Sydney, on November 15, 1918, Dr. A. A. Palmer, the President, in the chair.

On the motion of Dr. F. P. Sandes, seconded by Dr. W. H. Crago, it was resolved that the new South Wales Practitioners' Emergency Fund Regulations be amended by the deletion of words vesting the Fund in the President and Honorary Treasurer of the Branch, and by the substitution therefor of words vesting the Fund in two members of the Council of the Branch, to be appointed from time to time by the Council.

Dr. F. P. Sandes also moved on behalf of the Council to amend the regulation of the Branch, in accordance with Articles 28-30, and By-Laws 33-40 of the British Medical Association, so as to provide for the election of a deputy representative to attend the Representative Meeting in Great Britain, on behalf of the Branch.

Dr. F. P. Sandes moved that the proposals of the Federal Committee of the British Medical Association in Australia, dealing with a Medical Officers' Relief Fund, be adopted. The proposals were as follows:—

(*i.*) That a federal fund be established by donations from members of the profession in all States.
(*ii.*) That is be vested in trustees appointed by the Federal Committee.
(*iii.*) That a local committee of management be appointed by the Branch Council in each State, to consist of three members of the British Medical Association.
(*iv.*) That the fund shall be used in assisting medical offiecrs who have been disabled, and the dependants of those who have died.
(*v.*) That the fund shall also be used to issue loans with or without interest to medical men who, on account of war service, may require temporary financial assistance.
(*vi.*) That to create the fund an effort be made in each State to secure at once as large initial individual donations as possible, or annual contributions.

Dr. Gordon Craig seconded the proposition, and it was unanimously adopted. It was also determined that the Council should nominate three Trustees, in accordance with the request of the Federal Committee.

# Naval and Military.

## CASUALTIES.

The 441st and 442nd lists of casualties sustained by Australian troops were released for publication on November 14 and 18, 1918, respectively. These two lists contain 2,577 names, and the deaths represent 17.8% of the total casualties.

It is announced that Lieutenant-Colonel Herbert Locksley St. Vincent Welch, D.S.O., has been wounded (second occasion).

The news has been received that Major George Grantham Anderson, Royal Army Medical Corps, died of illness on November 4, 1918.

## HONOURS.

The Military Cross has been awarded to Captain Algernon George Rowley Lilford and Captain Donald Walter McCredie.

## APPOINTMENTS.

The following announcements of appointments, etc., have appeared in the *Commonwealth of Australia Gazette*, No. 179, of November 14, 1918:—

### Australian Imperial Force.

*Army Medical Corps.*

Lieutenant-Colonel T. P. Dunhill has been appointed Consulting Surgeon in Rouen Area, and is granted the temporary rank of Colonel whilst so employed. Dated 14th July, 1918.

Major F. H. Langlands to be Surgical Specialist, First Australian General Hospital, and to be temporary Lieutenant-Colonel whilst so employed. Dated 1st August, 1918.

Captain W. R. Young to be Registrar, First Australian Dermatological Hospital, and is granted the temporary rank of Major whilst so employed. Dated 1st June, 1918.

Lieutenant-Colonel A. G. Butler, D.S.O., to command Third Australian General Hospital, and to be temporary Colonel whilst so employed. Dated 27th July, 1918.

Lieutenant-Colonel (temporary Colonel) J. S. Purdy, D.S.O., relinquished the temporary rank of Colonel on ceasing to command Third Australian General Hospital. Dated 29th June, 1918.

Major J. Reiach to be Lieutenant-Colonel. Dated 20th July, 1918.

Major R. W. W. Walsh, D.S.O., to command Fifteenth Field Ambulance, and is granted the temporary rank of Lieutenant-Colonel whilst so employed. Dated 12th July, 1918.

Major (temporary Lieutenant-Colonel) M. W. Cave relinquished the temporary rank of Lieutenant-Colonel. Dated 5th May, 1918.

*To be Captains—*

John Allan Roy Mitchell. Dated 2nd October, 1918.
Captain A. R. Thorne. Dated 12th October, 1918.
Leonard Walter Johnston. Dated 16th October, 1918.

### Australian Military Forces.

*Second Military District.*

*Australian Army Medical Corps Reserve—*

Honorary Captain A. S. Rubinowich is transferred from the Australian Army Medical Corps Reserve, Third Military District. Dated 1st October, 1918.

*Third Military District.*

*Australian Army Medical Corps Reserve—*

Honorary Captain A. S. Rubinowich is transferred to the Australian Army Medical Reserve, Second Military District. Dated 1st October 1918.

Promotions made for specially meritorious service during the present war. Dated 3rd June, 1918:—

*To be Brevet-Majors—*

Captain A. M. Wilson, Australian Army Medical Corps, Third Military District.
Captain J. B. F. McKenzie, Australian Army Medical Corps, Second Military District.
Captain W. L. Crowther, Australian Army Medical Corps, Sixth Military District.

*Temporary Appointments.*

Honorary Captain A. Wadsworth, Australian Army Medical Corps Reserve, to be Officer-in-Charge of Base Depôt of Medical Supplies, Second Military District, temporarily, with pay at the rate of £350 per annum inclusive of all allowances except travelling,

whilst hold such appointment. Dated 25th October, 1918.

The undermentioned, who have served in the Australian Imperial Force as Commissioned Officers, having the rank held by them in the Australian Imperial Force confirmed as Honorary Rank in the Australian Military Forces:—

*Second Military District.*

*To be Honorary Major—*

Honorary Captain H. Stoker, V.D., Australian Army Medical Corps Reserve. Dated 6th July, 1916.

*Third Military District.*

*To be Honorary Major—*

Honorary Captain J. K. C. Laing, Australian Army Medical Corps Reserve. Dated 16th April, 1918.

*Fourth Military District.*

*To be Honorary Major—*

Honorary Captain W. J. W. Close, Australian Army Medical Corps Reserve. Dated 29th January, 1917.

# Public Health.

## NEW SOUTH WALES.

The following notifications have been received by the Department of Public Health, New South Wales, during the week ending November 9, 1918:—

| | Metropolitan Combined District. Cs. | Dths. | Hunter River Combined District. Cs. | Dths. | Rest of State. Cs. | Dths. | Total. Cs. | Dths. |
|---|---|---|---|---|---|---|---|---|
| Enteric Fever .. | 6 | 3 | 1 | 0 | 7 | 0 | 14 | 3 |
| Scarlatina .. .. | 7 | 0 | 0 | 0 | 8 | 0 | 15 | 0 |
| Diphtheria .. .. | 15 | 1 | 8 | 0 | 29 | 1 | 52 | 2 |
| *Pul. Tuberculosis | 29 | 21 | 0 | 0 | 0 | 0 | 29 | 21 |
| C'bro-Sp'l Mening. | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |

* Notifiable only in the Metropolitan and Hunter River Districts, and, since October 2, 1916, in the Blue Mountain Shire and Katoomba Municipality.

## VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, during the week ending November 10, 1918:—

| | Metropolitan. Cs. | Dths. | Rest of State. Cs. | Dths. | Total Cs. | Dths. |
|---|---|---|---|---|---|---|
| Enteric Fever .. .. .. | 0 | 0 | 4 | 1 | 4 | 1 |
| Scarlatina .. .. .. | 31 | 0 | 15 | 0 | 46 | 0 |
| Diphtheria .. .. .. | 79 | 2 | 36 | 2 | 115 | 4 |
| Pulmonary Tuberculosis | 18 | 8 | 10 | 4 | 28 | 12 |
| Puerperal Fever .. .. | 1 | — | 1 | — | 2 | — |

## QUEENSLAND.

The following notification have been received by the Department of Public Health, Queensland, during the week ending November 9, 1918:—

| Diseases. | No. of Cases. |
|---|---|
| Enteric Fever .. .. .. .. .. .. .. .. | 5 |
| Scarlatina .. .. .. .. .. .. .. .. .. | 7 |
| Diphtheria .. .. .. .. .. .. .. .. .. | 38 |
| Pulmonary Tuberculosis .. .. .. .. .. .. | 8 |
| Erysipelas .. .. .. .. .. .. .. .. .. | 1 |
| Puerperal Fever .. .. .. .. .. .. .. .. | 2 |
| Anchylostomiasis .. .. .. .. .. .. .. .. | 2 |

## WESTERN AUSTRALIA.

The following notifications have been received by the Department of Public Health, Western Australia, during the week ending November 2, 1918:—

| | Metropolitan. Cases. | Rest of State. Cases. | Totals. Cases. |
|---|---|---|---|
| Enteric Fever .. .. .. .. .. | 1 | 1 | 2 |
| Scarlatina .. .. .. .. .. | 18 | 6 | 24 |
| Diphtheria .. .. .. .. .. | 9 | 2 | 11 |
| Pulmonary Tuberculosis .. .. | 6 | 3 | 9 |

## TASMANIA.

The following notifications have been received by the Department of Public Health, Tasmania, during the fortnight ending November 9, 1918:—

| Diseases. | Hobart. Cases. | Country. Cases. | Whole State. Cases. |
|---|---|---|---|
| Scarlatina .. .. .. | 1 | 3 | 1 | 5 |
| Diphtheria .. .. .. | 1 | 4 | 9 | 14 |
| Pulmonary Tuberculosis | 3 | 0 | 4 | 7 |
| C'bro-Spinal Meningitis | 0 | 0 | 1 | 1 |

## INFECTIVE DISEASES.

In the last eight issues of the Bulletin of the Quarantine Service, issued between the dates of July 5 and October 11, 1918, information is given concerning the distribution of various quarantinable diseases. The following is a summary of this information.

### Variola.

There appears to have been 703 cases of small-pox and 114 cases of varioloid reported in the Philippine Islands between May 19 and the end of August. The number of deaths from small-pox was 469, and from varioloid 5. During the period covered by the bulletins there were 663 cases of variola in the Dutch East Indies, with 476 deaths. Between May 11 and August 3, 1918, 47 deaths from this disease were recorded in Calcutta. In the United States of America there were nine cases of variola in San Francisco at the end of April, five cases in California at the end of May, and six cases, with one death, in New York between March and June. One case was also reported in Portland during April. In Canada there were seven cases in May, while one death was reported in Rangoon (Burma) in the first week in June.

### Plague.

During the period April 21 to July 29 there were 86,511 cases of plague in India and 70,848 deaths. In Hong Kong between May 23 and September 14 there were 241 cases, with 196 deaths. Between May 23 and August 1 there were 268 cases and 105 deaths in Egypt. During the period from April 23 to August 12 there were 150 cases, with 144 deaths, in Java. The number of deaths recorded in Rangoon, Java, during the week ending June 8, 1918, was 30. In Ceylon the disease appears to have been moderately prevalent at Columbo, 20 cases having been reported between April and August. In the Straits Settlements there were 21 cases, with five deaths, at Penang, between June 21 and October 8, and seven cases, with eights deaths, between June 15 and September 25 at Singapore. A note is published concerning the reappearance of plague in Rhodesia, South Africa. Up to May 9, 1918, 59 natives were affected, and 56 died.

### Cholera.

From the reports received at the time of the publication of the eight Bulletins from the Dutch East Indies, it appears that 946 cases of cholera had been notified to the public health authorities, and 596 deaths. Cholera was prevalent at Calcutta in May, but became less frequent during the following months. Between May 11 and August 2 there were 71 deaths from this disease. During the last week in September there were five cases of cholera, with four deaths, at Manilla, in the Philippine Islands.

### Meningitis.

The information concerning the incidence of cerebro-spinal meningitis in the various parts of the world appears to be very incomplete. Mention is made of 165 cases between the middle of June and the middle of August at Kobe, in Japan, and 17 cases at Nagasaki between the middle of June and the middle of July. In Hong Kong, from June 17 to the end of July there were 27 cases, with 19 deaths. Between April 20 and May 4 there were six cases, with three deaths, at San Francisco. On July 17, 1918, the auxiliary schooner *Gilbert Island* from Tarawa, Gilbert Islands, put into Trial Bay, New South Wales, with a passenger on board who was found to be suffering from cerebro-spinal meningitis.

### Typhus Fever.

It appears that the regular records of the distribution of typhus fever issued by the United States Public Health Service have been discontinued. Only one table is published, which covers the period from April 13 to April 19, 1918. From this table it appears that typhus was prevalent in Java and Greece. No information is given in regard to the number of cases reported in Russia.

## Vital Statistics.

### TASMANIA.

The following information is culled from the monthly reports of the Government Statistician on the vital statistics of Hobart, Launceston and the country districts of Tasmania for the months of April, May, June, July, August and September, 1918.

The number of births registered in Hobart during these six months was 690. The largest monthly increment of population was in August, when 122 births were notified, and the smallest in September, when the number was 106. The number of births registered in Launceston was 458, the monthly returns varying between 71 and 79. This gives an urban figure of 1,148. In the rural districts the births numbered 1,597. In September 289 births were notified, while in June there were 241. The figures for the other months lay between these extremes. The total number of births in Tasmania was 2,745. Expressed as annual birth-rate per 1,000 of population, the six months' returns are equivalent to 34.26 for Hobart, 36.66 for Launceston, 34.82 for the urban districts, 23.17 for the rural districts and 26.82 for the whole of Tasmania.

There were 278 deaths registered in the Hobart district, and 191 in the Launceston district. In Hobart the smallest number of deaths took place in July (42), and the largest in August (51). In Launceston the smallest number was in April (29), and the largest was in May (35). The total number of deaths in the urban areas was consequently 469. The number of births notified in the rural districts was 427. The lowest figure was 62, in September, and the highest 81, in April. The total number of deaths for Tasmania was 896. The death-rates, expressed as annual death-rate per 1,000 of population, for the six months were 13.78 for Hobart, 15.28 for Launceston, 14.36 for the urban district, 6.19 for the rural district and 8.98 for the whole State. These figures are calculated on the estimated population as follows: Hobart 40,352, Launceston 24,981, rural districts 137,844, giving a total population of 203,177. Information is given concerning the number of deaths of infants under 12 months of age in the urban districts only. The total number of deaths of infants in the Hobart district was 49, and in the Launceston district was 24. These figures yield an infantile mortality rate of 71.01 per 1,000 births for Hobart, 52.4 for Launceston and of 63.58 for the combined urban districts.

The information concerning the causes of death is also incomplete. During the course of the six months, from April 1, 1918, to September 30, 1918, cardio-vascular diseases were responsible for 59 deaths in Hobart and 29 in Launceston. The number of deaths in the rural districts from these affections is not given. It will be noticed that this group of causes was responsible for 18.7% of the urban deaths. Tuberculosis killed 22 people in Hobart, 16 people in Launceston and 21 people in the rural districts. There were 14 deaths from pneumonia in Hobart and 11 in Launceston. The number in the rural districts is not given. Diphtheria was responsible for two deaths in Hobart, three in Launceston and seven in the rural districts; enteric fever for two in Hobart, five in Launceston and two in the rural districts; diarrhœa and enteritis for five deaths in Hobart and two in Launceston; cerebro-spinal meningitis for three in Launceston and syphilis for one in Hobart. The deaths from cancer numbered 21 in Hobart, 20 in Launceston and 26 in the rural districts.

. . . . . .

In a separate report the Government Statistician summarizes the vital statistics for the whole year of 1917. Unfortunately, the return deals primarily with the urban districts and contains but few details concerning the rural districts. The total number of births in Hobart and and its district was 1,340, and in the Launceston district was 802. The birth-rate for Hobart was 33.94, for Launceston was 32.80 and for the urban districts was 33.5. The number of births in the whole of Tasmania was 5,376, and the birth-rate was 27.03.

The number of deaths registered in the Hobart area was 499, in the Launceston area was 296 and in the rural districts 973, making a total for Tasmania of 1,768. The death-rate for the Hobart district was 12.64 per 1,000 of population, for the Launceston district was 12.11 and for the whole of Tasmania was 8.89. The number of deaths of infants under one year of age was 75 in Hobart, 51 in Launceston, 155 in the rural districts and 281 in the whole of Tasmania. The infantile mortality was 56 for Hobart, 64.54 for Launceston and 52.27 for the whole of Tasmania.

Among the causes of death, heart diseases and cerebral hæmorrhage, as is usual, occupy the first place. There were 299 deaths from these causes in the whole of Tasmania. Of the infective processes tuberculosis comes first, with 122 deaths; pneumonia and broncho-pneumonia comes second, with 96 deaths; diarrhœa and enteritis is third, with 70 deaths; and diphtheria takes the fourth place, with 37 deaths. There were 17 deaths from enteritis, six from influenza, five from pertussis, nine from cerebro-spinal meningitis, and the same number from simple meningitis, four from dysentery, and one from morbilli. Cancer killed 155 persons.

## Hospitals.

### THE VICTORIAN EYE AND EAR HOSPITAL.

The Committee of Management of the Victorian Eye and Ear Hospital have been wise in issuing their annual report before the Paper Controller has intervened. The report takes the form of a booklet of 34 pages, exclusive of the cover, profusely illustrated. We envy the publication its excellent super-calender paper. There are ten pages of donations and subscriptions, over three pages of "the local distribution of patients," two pages of life governors, three pages of the report proper, four pages of financial statements, three pages of lists of operations, etc., and, we regret to say, two pages of advertisement of the honorary staff. These annual publications are distributed largely for the purpose of obtaining financial support to the hospital concerned. This object has our fullest sympathy, although it frequently appears to us that a direct appeal, unassociated with the record of the technical work accomplished, would be more desirable. It is, in our opinion, highly undesirable that medical practitioners, who hold positions as honorary or salaried medical officers, should allow their appointments to be advertised in what is nothing more or less than a public appeal.

There were 68 patients in the hospital on July 1, 1917. During the twelve months ensuing 1,195 patients were admitted, and on June 30, 1918, 75 patients were still under treatment. During the course of the year 1,181 patients were discharged, and seven died. The mortality rate was 0.58%. The total number of operations performed was 2,007. In the Out-Patient Departments 9,603 persons received treatment. Of these, 8,487 were new patients, and 41% of them were children under the age of 15. About one quarter of the patients in the hospital were also under the age of 15. Both the in-door and the out-door practice has increased greatly during the past 41 years.

The Honorary Secretary points out that the greatest care is taken to prevent any abuse of the charitable nature of the institution being made. "No patient, knowingly, after due enquiry, is admitted if able to afford the expense of private treatment by the medical profession, and no patient unable to pay any fee is ever refused."

Suitable reference is made to the resignation of Mr. T. J. Davey from the position of President of the Hospital. Mr. Davey served in this capacity for 21 years, and has been associated with the institution for 39 years.

Considerable anxiety has been caused by the fact that the year ended with a deficit balance of £442. The Treasurer is faced with the difficulty of the increasing costs of provisions, drugs, etc., and of salaries and wages, and a material

reduction in the Government grant. The cost of maintenance for the financial year was £7,352. The Government provided £808, which municipal grants amounted to £295. Local contributions yielded over £2,000, sales, amounts refunded, etc., added another £623, interest from investments provided £440, and the patients' contributions aggregated £2,683. On September 13, 1918, the bank overdraft on the maintenance account stood at £1,035. Since it is improbable that in these days of the national obligations of citizens, voluntary contributions to hospitals will be materially extended, it becomes essential for the Government to find a sufficient amount of money to meet the reasonable expenditure of this most excellent institution.

## Correspondence.

### THE ENQUIRY ON VENEREAL DISEASES.

Sir,—I am informed that a report is current that I am receiving a large sum of money for conducting an enquiry into venereal diseases. In fairness to myself, I must state that is not so. I am not even receiving out-of-pocket expenses, though I have paid a number of visits to country towns in New South Wales and the other States, in pursuance of the enquiry.

Yours, etc.,
RICHARD ARTHUR.

211 Macquarie Street, Sydney.
(Undated.)

## Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xiii.

In future, no advertisements inviting applications from medical practitioners for positions in public institutions will be accepted unless the appointment is limited to medical practitioners who are ineligible for military service, or who have returned from military service. The term "ineligible for military service" is used to signify practitioners who are above military age, those who have offered their services and have not been accepted by the military authorities, or those who, for valid reasons, are incapable of applying for a commission in the Australian Army Medical Corps.

Red Cross Sanatorium, Wentworth Falls, N.S.W., Assistant Medical Superintendent.

Gladstone Hospital, Queensland, Medical Officer.

## Medical Appointments.

### IMPORTANT NOTICE.

**Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.**

| Branch. | APPOINTMENTS. |
|---|---|
| **VICTORIA.** (Hon. Sec., Medical Society Hall, East Melbourne.) | All Friendly Society Lodges, Institutes, Medical Dispensaries and other contract practice.<br>Australian Prudential Association Proprietary, Limited.<br>National Provident Association.<br>Mutual National Provident Club. |
| **QUEENSLAND.** (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.) | Australian Natives' Association.<br>Brisbane United Friendly Society Institute.<br>Rockhampton Associated Friendly Societies.<br>Cloncurry Hospital. |
| **SOUTH AUSTRALIA.** (Hon. Sec., 3 North Terrace, Adelaide.) | Contract Practice Appointments in South Australia.<br>Contract Practice, Appointments at Renmark. |
| **WESTERN AUSTRALIA.** (Hon. Sec., Health Department, Perth.) | All Contract Practice Appointments in Western Australia. |
| **NEW SOUTH WALES.** (Hon. Sec., 30-34 Elizabeth Street, Sydney.) | Australian Natives' Association.<br>Balmain United F.S. Dispensary.<br>Canterbury United F.S. Dispensary.<br>Leichhardt and Petersham Dispensary.<br>M.U. Oddfellows' Med. Inst., Elizabeth Street, Sydney.<br>Marrickville United F.S. Dispensary.<br>N.S.W. Ambulance and Transport Brigade.<br>North Sydney United F.S.<br>People's Prudential Benefit Society.<br>Phœnix Mutual Provident Society.<br>F.S. Lodges at Casino.<br>F.S. Lodges at Lithgow.<br>F.S. Lodges at Parramatta, Auburn and Lidcombe.<br>Newcastle Collieries — Killingworth, Seaham Nos. 1 and 2, West Wallsend. |
| **TASMANIA.** (Hon. Sec., Macquarie Street, Hobart.) | Medical Officers in all State-aided Hospitals in Tasmania. |
| **NEW ZEALAND: WELLINGTON DIVISION.** (Hon. Sec., Wellington.) | Friendly Society Lodges, Wellington, N.Z. |

## Diary for the Month.

Nov. 26.—N.S.W. Branch, B.M.A., Medical Politics Committee; Organization and Science Committee.
Nov. 26.—Vic. Branch, B.M.A., Ballot Paper for Election of Office-bearers issued.
Nov. 27.—Vic. Branch, B.M.A., Council.
Nov. 28.—S. Aust. Branch, B.M.A.
Nov. 29.—N.S.W. Branch, B.M.A.
Dec. 3.—N.S.W. Branch, B.M.A., Ethics Committee.
Dec. 3.—Vic. Branch, B.M.A., Ballot Papers for Election of Office-bearers Returned.
Dec. 4.—Vic Branch, B.M.A., Annual; Election of Office-bearers.
Dec. 6.—Q. Branch, B.M.A.
Dec. 10.—Tas. Branch, B.M.A., Council and Branch.
Dec. 10.—N.S.W. Branch, B.M.A., Executive and Finance Committee.
Dec. 11.—South Sydney Med. Assoc. (N.S.W.).
Dec. 12.—Vic. Branch, B.M.A., Council.
Dec. 13.—S. Aust. Branch, B.M.A., Council.
Dec. 13.—N.SW. Branch, B.M.A.
Dec. 17.—N.S.W. Branch, B.M.A., Medical Politics Committee; Organization and Science Committee.

### EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.

All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.